

COMMUNITY ENGAGEMENT PROJECT
(NIHME Mental Health programme)

Domestic violence and mental health:
experiences of South Asian women in Manchester

Report of the community-led research project on the mental health needs of South Asian women who are survivors of domestic violence

BY

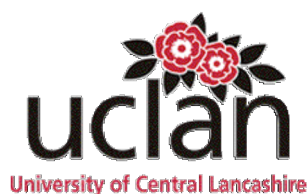


SAHELI ASIAN WOMEN'S PROJECT, MANCHESTER

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The following people were involved in the development and delivery of this project:

Dr Sundari Anitha (Researcher):

My current appointment is as Research Fellow, School of Politics and International Studies, University Of Leeds, where I am researching South Asian women's participation in the Grunwick and Gate Gourmet industrial disputes. My research interests lie in two areas: (i) issues of race and ethnicity, gender and working lives among the South Asian diaspora in the UK; and (ii) the problem of violence against Black and minority ethnic women in the UK, and social policy and criminal justice responses to this problem. I have been active in campaigning and policy-making on violence against women, including forced marriage, for over ten years and have previously managed a generic refuge and have experience of frontline work in a specialist refuge.

My role in this project has been to help the research team with the design of the research instruments, provide support to the community researchers on matters arising during fieldwork, conduct the data analysis and write the report. During this entire process I have consulted and drawn upon the insights and experiences of the other members of the team.

Priya Chopra (Project Manager):

I am the Project Coordinator for Saheli and Hosla Project. I have recently completed my Masters in Business Administration. Within my role as Project Manager for the research, I have ensured that the planning stage of the project really took into consideration the views and opinions of our service users, particularly around the understanding of mental health issues among South Asian women and the role of support and services.

I have been involved in analysing the data and working closely with the researchers and support worker. I have been involved in making links within other projects and to ensure that the women with various support needs are able to participate.

Waheeda Farouk (Community Researcher):

I am from Pakistan where I was a science teacher and I have a Masters Degree in Zoology. I am a housewife and I have a five year old daughter. I am one of the volunteers in this project.

Being involved in this study has taught me many things about mental health, by attending mental health workshops, I learned lots of things that were totally new for me. I hope that the research has been beneficial for Asian women and this will help improve services offered to them.

Qmar Jawaaid Haq (Community Researcher):

My name is Qamar Jawaaid Haq and I am from Pakistan. I have an Msc in Psychology from Karachi University, where one of my optional subjects included Educational Psychology. I have fourteen years experience of teaching children aged between 6 years and 15 years. I have also worked for six years with Dr Syed Mubin Akhtar, a psychiatrist from the US, during which time I gained a teaching experience certificate.

My other work has included eight years as a principal in a middle school. Due to my personal experiences, I can relate to the issues faced by South Asian women fleeing

domestic violence. I am proud to be part of the community engagement research project with Saheli exploring the mental health needs of South Asian Women.

Saliya Khan (Lead Community Researcher):

I have recently successfully completed my certificate in social sciences with the Open University. This course allowed me to develop a greater understanding of society and its influence on the individual. I have used this knowledge and my previous experience of working in social services, along with my experiences in mental health and domestic violence, to help lead the researchers involved in this project to develop a questionnaire and gather and collate information successfully.

I wanted to work on this project because I strongly believe in the need for more appropriate and responsive services for South Asian women who have suffered domestic violence and hope this project will help achieve this in some way.

Aqila Mansoor (Community Researcher):

I am from Pakistan, where I was a teacher and have a Masters Degree in Economics. I have done some useful courses since I came into this country, e.g. ESOL, community interpreting, classroom assistant, Urdu (A level) CLAIT (computer course) word processing in Urdu and a parent survival course and a Human Rights advocacy course. I have also taken a certificate in community based Research and Mental Health at the University of Central Lancashire.

I have also previously participated in a community engagement project with the HARP on refugees and asylum seekers.

I work as a volunteer with different refugee oriented organisations such as Routes Project (Black health agency) and British Red Cross. I was able to communicate well with many Asian women and get the input needed to give policy makers an overview of the complex situation of mental health in the community.

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Executive Summary

Introduction

This research was conducted to gain an understanding of the mental health needs and service experiences of South Asian women who are survivors of domestic violence to inform better policy and practice and to improve the engagement of Saheli in shaping mental health services as highlighted in ‘Delivering Race Equality’.

The Centre for Ethnicity and Health, University of Central Lancashire’s (UCLan) model of community engagement guided this project which was managed by Saheli, which provides domestic violence services to South Asian women in Manchester. The researchers who conducted the interviews were self-selected service-users and volunteers of Saheli who were trained and supported through this process by staff at UCLan and Saheli. Semi-structured interviews were conducted in 2007 with a total of 72 South Asian women living in the Manchester city who had experienced domestic violence. The focus of the interview design was on women’s understanding of domestic violence and mental well-being, their experiences within abusive relationships and their experience of contacting a range of services for help with domestic violence and/or their mental health needs.

Domestic violence and mental well being: definitions, prevalence, perceptions

The women interviewed for this research recounted experiencing a wide range of abusive behaviour. 50% of the women reported experiencing physical violence from their husband and/or their in-laws and in some cases from their parental family in the context of forced marriage, while a range of controlling behaviour, isolation, verbal abuse, financial abuse was more commonly experienced by women in this sample. Thirty one women (43%) were still living within the abusive relationship.

South Asian survivors of domestic violence and particularly women currently experiencing domestic violence reported high rates of mental health problems including sleeping and eating difficulties, extreme fears, panic attacks, depression, self-harm, suicidal thoughts and suicide attempts. An overwhelming majority of these women

articulated a direct and causal link between their experiences of domestic violence and their mental health problems.

Women's experience of help-seeking from formal sources of support and services

Contrary to popular perceptions, the South Asian women in our sample did access services, often repeatedly and with varying degrees of success, for help with the abuse they were facing and their mental health needs (often) arising from their experience of domestic violence. Each woman, on average, contacted 6.4 different services.

However, women's evaluation of service provision depended on whether they felt enabled to articulate their experience of domestic violence and problems relating to their mental health, whether they felt validated when they made disclosures, and whether the service was effective in recognising and meeting women's specific needs. Women expressed greatest satisfaction with specialist domestic violence services, obstetric services and voluntary sector mental health services; NHS mental health services, generic domestic violence services including refuges, police and complementary therapies received mixed reviews from the women; while women remained most dissatisfied with General Practitioners and Accident and Emergency services.

Women's experience of contacting services for help with mental health problems

General Practitioners (GPs)

Among formal services, GPs were the first port of call for a majority of women. Women's experiences indicate that GPs frequently engaged with the symptoms presented to them but not its causes; offered medication without simultaneously offering counselling; and were not consistent in offering advice and information and signposting South Asian women to relevant services for domestic violence. In some cases where such issues were addressed, women reported high levels of satisfaction with their GPs.

NHS mental health services

Women reported some positive experiences with individual practitioners. However, on the whole, women's experience of NHS mental health services were variable and inconsistent for reasons including the inability of services to meet women's needs, the

lack of understanding of the cultural context within which women were located and/or the context of the abuse they had faced.

Women's experience of contacting services for help with domestic violence

Specialist domestic violence services

Specialist services received the most positive feedbacks from South Asian women for providing effective, accessible, intensive and long term support that enabled many women to leave abusive relationships, and provided support where women continued to live within the abusive relationship. However, the need for support and services for South Asian women's mental health problems often continues long after the violence has ended; and specialist domestic violence services need to take this into account in service planning and provision.

Generic services – refuges, helplines and outreach services

These services received mixed reviews from the women. A few women who had stayed at generic refuges recounted initial relief at finding a place of safety, but reported encountering a range of difficulties including lack of emotional support from other residents, isolation and inability to recognise or meet South Asian women's specific needs such as language needs or the need for advocacy. Some of these problems were also reported for domestic violence helplines and outreach services, particularly the absence of support for women who were not able to or did not wish to take the route of exit.

Accident & Emergency services (A&E)

Women uniformly reported dissatisfaction with A&E services for their failure to probe the causes of their injuries.

Obstetric services

Where language barriers had been overcome, women's experiences with health visitors and midwives were positive, and women reported pro-active questioning about domestic violence and where they disclosed domestic violence, they had been offered help and referral. Even when women had not been able to make full disclosures or felt unable to act on the advice they were given, they valued knowing that help and support was available. The knowledge of services gained through this process helped some women reassess their options at a later date.

Social services

Evaluations of social services were evenly divided between women who were enabled to leave the abusive relationships due to support from the social services, and other women who did not receive such help due to reasons including language barriers, lack of cultural competence on part of the service and the Local Authority policy towards women with insecure immigration status.

Police

Over a third of women reported positive experiences when they called the police for help with the violence they were facing, while just under two-thirds of the women remained dissatisfied because of reasons including the failure of the police to take any action against the perpetrator(s), take the woman's statement, use interpreters where needed and/or offer appropriate referrals or signposting to services.

Law centres and Citizens Advice Bureaus

Overall, women reported benefiting from these services, with women who had advocates reporting better experiences than those who did not.

Voluntary sector mental health services

The primary mode of referral to these services was through domestic violence services, and women made particularly positive assessments of The Roby, where specialist needs seemed to be recognised and addressed at the institutional level, and benefited from services provided at Neesa.

Community organisations and faith groups

Women who accessed these organisations reported benefits such as overcoming isolation and improving life skills through ESOL, computer classes etc where these were provided. However, most women did not find these services effective in enabling their disclosures of the abuse, validating their experiences or directing them to appropriate help with the domestic violence they were facing.

Women's experience of complementary therapies

Complementary therapies were widely used, particularly where they were provided by a community organisation or a domestic violence service. Women reported that alternate

therapies like massage, homeopathy, reiki and use of fitness centres have provided a valuable forum for interaction, exchange of information (about other services) and a counter to isolation, particularly where women's access to other services was limited due to constraints imposed by their family. However, these services seldom managed to engage with their mental health problems or enable disclosure of domestic violence.

Recommendations

1. There is an urgent need to make more effective and efficient use of resources to address both short-term and long-term impact of domestic violence on South Asian women's mental health.
2. The inability of mainstream services to meet South Asian women's specific needs, including but not limited to language needs, impedes South Asian women's ability to access these services or receive effective help from them. Mainstream services need to address women's specific needs; there also remains an urgent need to secure specialist provision which has received most positive evaluations from women.
3. Other recommendations include promoting multi-agency working so that mental health and domestic violence services can benefit from each other's competencies, provide training to each other, and develop effective policy and practice guidelines to address the issues arising from the links between domestic violence and mental health.
4. There is a need for awareness raising, education and preventative work to address the shame and stigma associated with the disclosure of domestic violence and the experience of mental health problems, and particularly to provide information about service provision.
5. Given South Asian women's reliance on informal sources of support and service referrals from family and friends, peer support would open up more pathways into services.
6. Most women interviewed had primary responsibility for childcare; given this, there is a need to improve access to childcare facilities to enable women to

benefit from services; agencies also need to evolve better ways of working with children in order to address the impact of witnessing domestic violence and their mother's mental health problems.

Conclusion

Given the overlap between domestic violence and mental health problems, services in both these sectors need to develop better protocols to tackle co-existing problems and to avoid both underutilisation and duplication of services. For women accessing mental health services because of the impact of the abuse they have faced, lack of engagement with the underlying causes often leads to poor outcomes and temporary management of the problems which are likely to recur without a change in their material circumstances. For women who are accessing domestic violence services, support around their mental health needs is crucial to overcome the emotional and mental impact of abuse. While complementary therapies play a crucial role in providing symptomatic relief and 'holding' women into services, their long term effectiveness depends on their ability to understand and develop effective responses to domestic violence and mental health problems. South Asian survivors of domestic violence report best outcomes where services work together across sectors and share their expertise. While examples of good practice exist, a lot remains to be done to improve services such that they can enable South Asian women to leave abusive relationships and to overcome the impact of the domestic violence on their mental health.

Acknowledgements

The Saheli/ Hosla research team would like to thank all the women who took part in this project, without whom this research would not have been possible. Staff at Saheli, particularly Sajida Anam and Manju Kaushal have continuously contributed time and resources to the project to ensure it is run efficiently and effectively. We would also like to thank:

Steering group

Shabana Baig (Project Worker, The Routes Project)

Elaine Dixon (Chief Executive, Health, Advocacy & Resource (HARP) Project)

John Macc (Manchester Alliance of Community Care)

Shabnam Sheikh (Development Worker, The Roby Project)

Manjeet Singh (Regional Race Equality Lead, CSIP(NW))

For facilitating access to research participants

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Pam Whittle and Val Nuttle (CMWA)

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Leena Kumarappan, who transcribed the interviews, and **Sundari Joshi** for her help with the graphs in the full report.

1. Community Engagement¹

1.1 The Centre for Ethnicity and Health's (CEH) model of community engagement

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be

¹ This chapter has been authored by staff at the (then) Centre for Ethnicity and Health, University of Central Lancashire.

done. If all the Department of Health had wanted was a needs assessment and a ‘glossy report’, they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health’s model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aim higher.

1.2 The key ingredients of the CEH Community Engagement Model

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community² (whoever this is) such that it is able to recruit a number of people from the target community take part in the project and to do the work (see section on task below). It is important that the host community organisation is able to provide a co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation

² The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

undertakes will be to recruit a number of people from the target community to work on the project.

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infrastructure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project.*

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers³. We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project at for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project⁴. The steering group is an essential element of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

1.3 The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme

³ This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

⁴ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

Senior Support Worker	Senior Support Worker	Senior Support Worker	Programme Advisors
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

1.4 Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and ‘hard to reach’ communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- the Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- the Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- all DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme. The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

1.5 The Focus of the NIMHE Community Engagement Project

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes. The aims of the National Institute for Mental Health in England Community Engagement Programme are to deliver improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- *building capacity in the non-statutory sector*
- *encouraging the engagement of Black and minority ethnic communities in the commissioning process*
- *ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector*
- *involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services*
- *ensuring greater community participation in, and ownership of, mental health services*
- *allowing local populations to influence the way services are planned and delivered*
- *contributing to workforce development, and specifically the recruitment of 500 Community Development Workers*

This chapter outlined the CEH model of community engagement and the structural arrangements that underpin the effective working of this model. The next chapter will focus on the design and methods of a specific research project that has utilised the community engagement model.

This section begins with the aims and objectives of the study and presents the process of community engagement through which the research was conducted. This is followed by a description of the data collection methods, limitations of the project, the ethical considerations, outline of data analysis and the structure of the rest of the report is laid out.

2.1 Aims and objectives

This research was conducted to gain an understanding of the mental health needs and service experiences of South Asian women who are survivors of domestic violence and are living in Manchester in order to inform better policy and practice.

Saheli is a voluntary sector organisation providing services to women and children who are survivors of domestic abuse by providing the following services:

- Emergency, temporary refuge accommodation to the victims of domestic abuse.
- Children's services within the refuge to ensure that children's needs are met through play sessions and one to one work.
- Resettlement and outreach support is provided to the women and their children, who are living in the community.

Saheli was one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The focus of this work is to assess the mental needs of South Asian women who are survivors of domestic violence and are living in Manchester.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health, University of Central Lancashire.

The objectives of this research were:

- To explore South Asian women's experiences and understandings about the links between domestic violence and mental health.
- To identify the mental health needs of South Asian women and children in Manchester who are survivors of domestic violence.
- To explore the experiences of South Asian women and children as they engage with domestic violence and mental health services, and complementary therapies.
- To identify the barriers that South Asian women and children face in accessing services, both in relation to their mental health needs and domestic violence.
- To generate recommendations that will inform the future service developments of specialist mental health services for South Asian women in partnership with the statutory sector, other voluntary organisation and commissioners.

Outcomes

One key aspect of this work is to improve the engagement of Saheli in shaping mental health services as highlighted in “Delivering Race Equality.” This outcome is to be met not only through the research findings which we hope will inform service development, but also through the particular process by which this research is being conducted: by building the capacity of community researchers to conduct this research and by enabling a better sharing of expertise between the statutory and the voluntary sector. While on one hand, this project is expected to build the capacity of Saheli to engage with commissioners, the involvement of commissioners in the research process is also geared towards providing them with insights into the workings of the voluntary sector.

2.2 Research design and the process of community engagement

This research was conducted using the community engagement model, which involved several stakeholders including the community researchers, representatives of statutory and voluntary services and the respondents.

Community researchers

The researchers were self-selected service users and volunteers of Saheli. A recruitment flyer was distributed to current and ex service users of Saheli and was also sent to agencies working with South Asian Women, other refugees and community groups. This

recruitment drive generated several responses which we followed up, based on certain criteria required of the researcher to enable them to carry out the research.

The researchers were involved in designing the research instruments with guidance from the steering group, contacting South Asian women in the community, making contact and links with other projects in Manchester, piloting the questionnaire, undertaking the fieldwork, contributing to the analyses of the data, attending the group meetings once a week, attending the steering group and network meetings and dissemination of findings. The University of Central Lancashire arranged seven days of workshops to train the researchers on mental health, research methods and techniques, including data analysis and report writing. The researchers were supported by their UCLan Support Worker through regular meetings and phone conversations, by the Project Coordinator who was based in Manchester and by the Independent Researcher. An action plan was drawn up as guiding tool to monitor the progress of the work undertaken and help the team to work to a timetable. The plan outlined the deadlines and targets.

Steering Group

In order to enable effective participation from a range of stakeholders, a multi agency steering group was formed which included membership from providers and commissioners of mental health services and from representatives of organisations providing domestic violence services. The purpose of the steering group was to provide support for the researchers, inform the strategy, monitor the development of the research project, and to engage the commissioners and other statutory and voluntary services in the process of the research. The research project manager, the lead researcher and the Support Worker met with the steering group six times during the course of the research. This group consisted of four members working in the relevant fields, and their comments and advice informed this study's research design and the recommendations.

Questionnaire

It was decided to use the semi-structured interviews to collect data, with a combination of closed and multiple-choice questions to enable the respondents to articulate their experiences in their own words. The questionnaires were designed by the researchers who have been informed by their perceptions about their community and their knowledge and understanding of issues facing South Asian women who have experienced domestic violence and mental health problems. This process was guided by

the steering group, and the questionnaire was piloted and some changes were made subsequently.

Translation

Once the questionnaire was finalised, the researchers who were competent in community languages (Hindi, Urdu and Punjabi) translated the questionnaire with feedback and clarification from the Project Manager and the Independent Researcher. One of the reasons for recruiting the Community Researchers was their language skills, which would enable them to reach out to non-English speakers, who are often excluded from such research due to the financial implications of providing interpreters. The research team are convinced that this strategy worked well and 45 interviews were conducted in languages other than English, primarily in Urdu, Punjabi and Hindi, as requested by the respondents. Due to the difficulty in recruiting a Bengali speaking researcher, the language needs of two Bengali speaking women could not be met, and the interviews with these women were conducted in their second language – one each in English and in Urdu.

The interview process

The researchers prepared the brief about the project, which was circulated to various domestic violence projects to recruit potential participants. Women were also recruited through other South Asian women's groups, community organisations and the researchers' own contacts within the community and snowballing technique in both cases. Semi-structured interviews were conducted with 72 South Asian women defined as women from India, Pakistan, Bangladesh, Sri Lanka and Nepal. Five women had dual heritage, but identified themselves as South Asian, while four women were from Afghanistan and had lived in Pakistan for many years before coming to the UK. Two women had married men from South Asian communities and identified themselves as South Asian due to their language and culture acquired after many years of living within the South Asian community in the UK.

Due to the sensitive nature of this project and the involvement of community researchers, there were some initial concerns about accessing respondents for this project. While the community engagement model enables access to the community through insiders, their privileged position as insiders can also create certain difficulties, such as the fear that researchers who are known to the respondents may not maintain

confidentiality. Much of the recent research that has been conducted on domestic violence in the UK has been from a feminist perspective that has sought to erase the distance between the so-called ‘experts’ and ‘non-experts,’ researcher and researched and recognise, if not redress the power imbalance between these categories (Kelly 1988; Yllo 1988). The model of community engagement used in this research, where the researchers were South Asian women who were themselves survivors of domestic violence and often users of services, experiences of which they were researching indeed went some way towards erasing these boundaries. While the researcher cannot but be present in a respondent’s utterances, these fuzzy boundaries had to be managed to ensure that the respondents were given the space to fully and safely articulate their own, sometimes divergent experiences of services. Listening to the voices of survivors in policy and service development is crucial to ensure that services meet women’s needs (Hague and Mullender 2006).

Given the sensitive nature of the research, respondents were signposted to relevant agencies where they could access support and advice. There were also ethical considerations that arose for the researchers, given their own experiences of abuse. Some of the researchers were residents of refuges or South Asian women who had been rehoused after having left abusive relationships and were still in the process of negotiating their belongingness within the community on somewhat different terms than before, and were sensitive to community perceptions about them. At the same time, interviewing women who were still experiencing abuse enabled some of the researchers to talk about their own experiences and the process of analysing the interviews took us through terrains that were familiar yet new, distanced yet too close for comfort. Saheli made the services of counsellors available for the researchers and some of the researchers also had access to their case workers to discuss any issues that the research raised for them. Group meetings and individual meetings with the lead researcher also provided the opportunity for such discussions. The research participants were also given information about existing services.

The financial resources available for this small pilot project and the time constraints meant that only 72 interviews with South Asian women could be held. Whilst participants were chosen from a wide range of communities and through a number of organisations to capture a variety of experiences, it cannot be guaranteed that the results from this study can be extrapolated to all members of these communities. For example,

the absence of a Bengali or Sylheti speaking researcher meant that Bangladeshi women could not be interviewed for this project unless they could speak English or Urdu. Nor, without further research, can these findings be extrapolated to women from other communities experiencing domestic violence and mental health problems. Nevertheless, the ongoing consultation process with those working in the mental health and domestic violence field that characterised this study has resulted in a valid pilot project, and results have provided insights that could be used to inform policy changes as well as a larger-scale study on the links between domestic violence and mental health problems amongst South Asian women in the UK.

2.3 Ethical considerations

The aims and objectives of the research project and the purpose of the interview was explained to the participants via an information sheet prior to their recruitment to the project, and also when the interviews took place. Interviews were conducted with individual women who were identified through Saheli and other partner agencies, representatives of organisations working in this area and through the researchers' contacts within their communities. As women's organisations, including Saheli, were often facilitating access to respondents, care was taken to guard against any risk of coercion to participate in the study, by informing the women of their right to refuse to participate, to withdraw from the research at any point and that this would not have any impact on any present or future access to services. The participants were informed of the full terms of their consent – these included information about the measures to respect confidentiality and preserve the anonymity of individuals and organisations. This information was provided verbally as well as in writing. All those participating in the interviews were given an information sheet on the project and the opportunity to ask questions, and, if they decided to participate, asked to sign a consent form. The interviewers met the interviewees in a mutually agreed location and with the consent of the research participant, the interviews were audio-taped and later transcribed or where this consent was withheld, contemporaneous notes were taken. All participants were informed of the measures in place to maintain confidentiality and anonymity.

All the data were handled according to the Data Protection Act 1998. Ethical approval for this project was obtained from the Centre for Ethnicity and Health at the University of Central Lancashire.

2.4 Data analysis

Microsoft Excel was used to analyse the quantitative data, while the qualitative data was coded and analysed using NVivo. The data from the interviews were analysed thematically, according to the themes that most consistently arose in the discussions and that are pertinent to project's aims. The use of a thematic analysis makes it possible to recognise the key issues emerging from the research, as well as to identify areas of consensus and divergence on specific issues. Women's own voices have been used to convey their experiences from their perspectives. However, this has often involved editing their utterances, for the sake of brevity or to protect their identity.

2.5 Structure of the report

Chapter 3 presents an overview of previous research on domestic violence, the link between domestic violence and mental health and the particular experiences of Black and minority ethnic women.

Chapter 4 presents the quantitative findings of this study.

Chapter 5 discusses these findings with reference to the aims of this research. The characteristics of the sample recruited for the study and any particular shortcomings arising from this sample are discussed. The following section presents definitions of domestic violence and emotional well-being articulated by the women and women's narratives about their experiences of domestic violence and mental health problems, and the links between them. Women's experiences of contacting services for help with the domestic violence or mental health problems, and their experience of complementary therapies is also explored here. Finally, this chapter reflects on the findings of the study as well as particular suggestions made by the participants to provide recommendations that address the gaps in services and possible ways forward.

3.1 What is domestic violence?

The Home Office defines domestic violence as ‘any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality.’⁵ There is also a recognition that ‘whatever form it takes, domestic violence is rarely a one-off incident. More usually it's a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim. Domestic violence is prevalent across different ages, race, sexuality, class and nationalities, and mainly consists mainly of violence by men against women.’⁶

Till very recently, the relationship between the perpetrator and the victim was defined as that of partners, ex-partners or intimate family members. Following critiques by Black and minority ethnic women’s organisations, this definition was expanded to include violence by family members in general, with some organisations like Women’s Aid and Southall Black Sisters including within the scope of this definition, ‘family-type relationships.’⁷ This definition includes all forms of abuse such as physical, emotional, financial, sexual, as well as culturally specific forms of domestic abuse like forced marriage, so-called ‘honour’ killings and dowry attacks.

3.2 Examining research evidence: how widespread is domestic violence?

In order to understand the prevalence of domestic violence accurately, there is a need to harmonise statistical data about the extent of the domestic violence. Not only are different definitions of domestic violence being used by different agencies, but the estimates also depend on the methods used to obtain statistics. These include self-report survey, direct interviewing, random sampling and reports to the police. In all these

⁵ <http://www.homeoffice.gov.uk/crime-victims/reducing-crime/domestic-violence> (accessed 18 Nov 2008)

⁶ <http://www.homeoffice.gov.uk/crime-victims/reducing-crime/domestic-violence> (accessed 18 Nov 2008)

⁷ http://www.womensaid.org.uk/landing_page.asp?section=0001000100050007 (accessed 18 Nov 2008)

methods, the reports of domestic violence are likely to be underestimates because of the unwillingness of survivors to report their experiences. A range of reasons for this reluctance could be fear of further violence, fear that the authorities will not believe them or trivialise their experiences, acknowledging that they are experiencing domestic violence may be difficult. Some Black and minority ethnic women might be afraid of shame or stigma, may additionally face language barriers or be deterred by fear of racist responses (Gill 2004 and 2006).

Domestic violence is the least likely violent crime to be reported to the police. Only one out of three crimes resulting in injury are reported (British Crime Survey 1996).

Sources of knowledge about extent of domestic violence include criminal statistics, national crime surveys and local surveys. Criminal statistics have traditionally been considered the 'barometer of crime' (Maguire 1994: 247). However, in the case of domestic violence, the problems with criminal statistics is that domestic violence is not a crime category; offences categorised as homicide, rape, grievous bodily harm, attempted bodily harm, common assault, public order, nuisance, harassment, criminal damage. Also, not all forms of domestic violence are classified as crime, so are not recorded.

Nevertheless, criminal statistics do have a role in illuminating the problem of domestic violence. A 24 hour snapshot survey conducted on Sept 28th 2000 by police forces in England, Scotland & Wales (Stanko 2000) showed that 999 calls reporting domestic violence were made every minute.

Domestic homicide statistics from British Crime Surveys over several years show that women are several times more likely to be killed by their partners than men. In 2005/2006, 82 women were killed by partners or ex partners in England and Wales, i.e. 33% of all women killed that year while 5% of men (23) killed that year were killed by (ex) partners. These figures do not include homicides by other family members.

British Crime Survey 2001 (Walby and Allen 2004) found huge differences in repeat victimisation and impact between men and women - 69% of men hit only once, while 57% of women repeatedly hit in previous year.

1 in 3 women had experienced domestic violence at some time in their lives (Mooney 1994).

12% of women had survived domestic violence in the past year (Mooney 1994)

3.3 Approaches to understanding domestic violence

Since the recognition of domestic violence as a social problem in the 1970s, there have been various approaches to understand and explain the causes of this violence and thereby suggest ways to end it. We can broadly categorise them as psychopathological approaches, ‘family violence’ perspectives and feminist and pro-feminist perspectives.

- **Psychopathological approaches**

Early research focussed on ‘why women stay’ in violent relationships and drew upon psychological explanations, rooted in individual behaviour and sought explanations of violence in women’s own personalities. Women were seen as dysfunctional (Shainess 1984) and thereby perversely implicated in the violence they faced and even held responsible for it (Gayford 1975; Pizzey and Shapiro 1982). While these victim blaming theories rely on psychodynamic explanations, the woman is similarly implicated in the behavioural theory of “learned helplessness” (Walker 1977-78), which views submission and suffering as a way of life which passive women learn to live with. Such attitudes continue to inform mainstream agencies’ responses to Black and minority ethnic women’s experiences of domestic violence. While this countered earlier masochism theories, the explanations of abuse were still individual centred, depoliticised and continued to focus on the personality of women, rather than on perpetrators (Dobash and Dobash 1992: 221-8). Accordingly, solutions centred on changing women’s behaviour through therapeutic work.

In general, researchers now accept that women as victims do not have psychological problems, e.g., attraction to men who are violent, or ‘learn to be helpless’ (Walker 1978). But men who use violence continue to be perceived as having psychological problems and their violence is viewed as being uncontrollable within this framework, and a result of a combination of abnormal personality traits and social strain: ‘When I got violent it was not because I wanted to get violent it was just because it was an outburst of rage’ (Hearn 1998). Such theories pathologise individual men, and argue that domestically violent men have border-line personality disorders, which can be the result of childhood

experiences, abnormal brain function, genetic disposition, use of alcohol/drugs. The solution that is posited is therapy, counselling or anger management training - individual solutions to what are seen as individual problems - but the underlying structural causes of the violence are not addressed.

- **Family violence perspectives**

‘Family violence’ is the term that is used to define all violence between family members including partner violence and child abuse and was initiated by US family sociologists (Straus and Gelles 1976). It is characterised by the way violence is researched in gender neutral terms and explained through theories of inter generational transmission of violence and concepts of ‘stress’ and ‘strain’.

Straus (1983) argues that children, in particular boys who grow up with violent fathers, are more likely to be violent towards women partners in adulthood. On the basis of a survey that has since been criticised for its flawed methodology, they also argued that men experience as much, if not more domestic violence than women. Generally, family violence researchers now accept that men are not usually victims of family violence in the same way as women are (see Gelles 1997). However, the myth of violent women and ‘battered husbands’ continues to be aired when statistics indicate that the vast majority of violence is from men to women. Gelles (1997) also argues that men are violent when they cannot fulfil their traditional roles as men - as breadwinners and head of families because they are unemployed or only employed part-time, or when they have low status in society. This, Gelles argues, results in role strain which itself leads them to violence to alleviate stress.

Feminists critique family violence perspectives for ignoring the gendered nature of domestic violence and understanding violence against women as ‘abnormal’ behaviour, which takes place in dysfunctional families. Concept of learned violent behaviour because of violent family history is not borne out by statistics, and it does not explain why it is men who learn to be violent. They also point to the functional view of family in concept of ‘stress and strain’ idealises ‘traditional’ view of family as well as implicates women in the violence they face for deviating from this norm.

- **Feminist and pro-feminist perspectives**

Instead of understanding why this particular man is abusive to this particular woman, feminists seek to understand why men in general abuse known women and what functions it serves for a given society in a specific context. Feminist understanding of domestic violence is geared towards challenging it, and securing change.

A key feature of feminist and pro-feminist perspectives is a critique of gendered division of public and private spheres. Feminists argue that the ideal of non-interference in the latter was not leaving individuals to be free; instead it was ignoring, thereby condoning and perpetuating the injustices that take place within the family. Despite legal and social policy responses to domestic violence, it continues to be under-emphasised in relation to crimes that take place in the 'public sphere.' For example, Home Office emphasis on 'stranger danger' does not reflect the reality of women's experience of crime, which is more likely to be from intimates (Stanko 1988).

Feminist perspectives on domestic violence also emphasise that what happens in the 'private sphere' has profound implications for the 'public sphere' and vice versa. From this perspective, domestic violence, like all forms of violence against women, is rooted in patriarchy, gender inequality and masculinity which exists in all social spaces, but is most evident within the family. Women are devalued and are subject to the exercise of power and control by men who seek to uphold these inequalities through devices such as gendered division of domestic labour. Men and women do not have to live up to similar expectations with regard to appropriate behaviour in family life. Behaviour that will define a woman as a 'bad wife' or 'bad mother' will not similarly label a man (Hanmer 2000; Jones 2000).

Early feminist perspectives on domestic violence have been criticised for their essentialism in viewing gender as the only explanatory factor. Mama (1990) highlighted the additional implications of race and ethnicity in conditioning the experience of domestic violence and the responses to it. She argued that fear of racist responses could act as barriers preventing Black and minority ethnic women from accessing services or speaking out about the domestic violence that they experienced. Culturally specific forms of domestic violence as well as the patriarchal constructions of concepts like 'honour' have also been highlighted by Gill (2006). Patel (2000) and Wilson (2006) draw attention to the twin difficulties faced by women in negotiating cultural-religious identity in the context of immigrant communities and the failure of the British state to

recognise the plurality of Black and minority ethnic communities within the policy of multiculturalism. However, recognising difference among women does not preclude the possibility of a feminist analysis (Hester, Kelly and Radford 1996; Wilson 2006). Women's responses to domestic violence are conditioned by their gender as well as the social construction of other identities. Saheli's work, including this research project, is firmly grounded in feminist politics and practice.

3.4 Domestic violence and mental health: South Asian women in the UK

Early theories on domestic violence sought to find explanations for the violence that women were facing in the state of their mind and personalities. Instead of viewing the psychological traits and behaviour patterns attributed to women experiencing domestic violence as pre-existing, contributory factors to the abuse, later psychologists reframed them as consequences of the abuse (Dobash and Dobash 1992: 213-230). They provided alternate psychological frameworks for understanding the behaviour of women experiencing domestic violence that was situation specific rather than trait specific. Research has shown that emotional effects of domestic violence include low self esteem, anxiety and depression (Campbell et al. 1995; Cascardi et al. 1999; Golding 1999; Humphreys and Thiara 2003; Kirkwood 1993; Mooney 1994). This link has only recently been highlighted in the Department of Health consultation document on women and mental health, *Into the Mainstream*, which, for the first time recognises how gender differences have an impact on women's experience of mental health problems and their service needs. This document highlights how women mental health service users are much more likely to have experienced domestic violence than women in the general population – at least 50% of women users of mental health services have experienced domestic violence (Bowstead 2000, cited in Barron 2002; DOH 2003; ReSisters 2002, cited in Barron 2002).

Another key area of research has explored the links between suicide and self-harm among survivors of domestic violence (Golding 1999; Stark and Flitcraft 1995) and research has found increased rates of suicides among this group of women. In addition, research indicates that even when women have managed to leave violent relationships, there are often long term effects on their mental health (Kirkwood 1993). Psychologists

have found parallels between the effects of domestic violence on women and the impact of torture and imprisonment on hostages (Graham et al. 1988). The emotional impact of domestic violence has also been documented to lead to the development of Post Traumatic Stress Disorder (Barnett and LaViolette 1993; Cascardi et al. 1999; Golding 1999). While this research usefully draws attention to very different societal attitudes and responses to survivors of a hostage situation or war and those of domestic violence, there is also a trend towards medicalisation and depoliticisation of women's experiences.

While this direct link between women's experiences of domestic violence and mental health problems has been well documented, there are additional risk factors for Black and minority ethnic women, particularly South Asian women in the diaspora (Anand 2005; Karasz 2005). A survey of hospital admissions for attempted suicide and self harm, many by attempted poisoning, showed that young South Asian women's rates of admission were three times those of white British women (Merril and Owens 1986). Research findings from one study indicate that the suicide rate found for South Asian women was nearly double their proportion of the population, with an excess mortality rate of 43% (Raleigh 1996), and in another study, suicide by burning was found to be nine times higher than the average for women of Indian origin (Raleigh and Balarajan 1992). Research has also documented the over-representation of young South Asian women among those self-harming (Bhugra et al. 1999a and 1999b; Husain et al. 2006; Yazdani 1998), and some of this research has also indicated links between mental health problems affecting South Asian women and their experience of domestic violence, including forced marriage (Chew-Graham et al. 2002; Gill 2004; Humphreys and Thiara 2003; Khan et al. 1996; Rethink 2006; Yazdani 1998).

While cultural concepts like stigma that act as a barrier in accessing both domestic violence and mental health services have been explored in previous research (Rethink 2006), attention to the socio-cultural context of domestic violence is often underpinned by stereotyped assumptions about South Asian women as passive in the face of non-negotiable cultural expectations. Dominant media discourses on violence against minority ethnic women, particularly on self-harm and suicide, portray non-Western women as inhabitants of cultures that are depicted as "patriarchal and inherently uncivilised" (Razack 2004, 129). Women within these communities are re-presented as particularly oppressed and lacking in agency, unlike the putatively liberated women in the West who are seen "as educated, as modern, as having control over their own bodies

and sexualities, and the freedom to make their own decisions” (Mohanty 1988, 65). These discourses also invoke specific cultural traits or religion (the two are often used interchangeably) to explain violence against Third World women, whereas culture is not similarly invoked to explain the forms of violence that affect mainstream Western women, a problem transnational feminist scholars have highlighted in other contexts (Narayan 1997, 84-85; Abu-Odeh 1997; Volpp 2000).

This colonial stance towards cultures of Black and minority ethnic communities conceives tradition as static and ahistorical, and thereby effacing all ideologies and politics that constitute a set of practices within a given context as ‘traditional’. Not only does this disregard the agency of women, whose resistance shapes the contours of what is constituted as culture, but by extricating gender from the social relations that produce particular constructions of femininities, the category of women in such scholarship is thereby homogenised as the perpetual victim-subject. Alongside this, what is also elided from these debates is any understanding of how the intersections between wider structures of inequalities such as class, state policies, racism and the relative positions of different countries in the international order shape particular experiences of violence and responses to recourse-seeking. Research on domestic violence has shown that women seldom remain passive – they test out their options, assess and re-assess their situation and constantly devise strategies to avoid or minimise the abuse and its impact on themselves and their children (Dobash et al. 1985; Hoff 1990), and research indicates that South Asian women are no exception to this, and exercise their agency in myriad ways despite and within the constraints they face, both within the abusive relationship and by seeking to leave (Chantler, 2006; Anitha and Gill 2008).

It is in this context that this study explores women’s experience of domestic violence and mental health problems, their perceptions of the link between domestic violence and mental health problems, how agencies understand and respond to women’s concerns, and women’s perceptions about their service needs.

3.5 Manchester: background information

Manchester, where this research was conducted, is the regional capital of the North West of England, and the UK’s largest economic region outside London. The region comprises some 2.5 million households, has a population of over six million and a GDP

of £50 billion. Manchester is the northwest's regional centre for finance, commerce, retail, culture and leisure, home to a major international airport and one of the largest student populations in Europe. However, despite its veneer of success, Manchester is a city of contrasts. Manchester also has some of the highest concentrations of crime, poor health and poor housing in the country with 27 of its 33 wards among the most deprived 10% nationally.

Manchester has lower average annual household income (£16,500) compared to the UK as a whole (£21,300) and to Greater Manchester (£19,400)⁸, a higher proportion of people on income support (20%) than the national (10%) and the average in Greater Manchester (13%), as well as a greater percentage of unemployed claimants (3.7%) compared to the national average and the Greater Manchester average (both 2.4%)⁹.

The Social Disadvantage Research Centre (SDRC) at the Department of Social Policy and Social Research at the University of Oxford, commissioned by the Office of the Deputy Prime Minister (ODPM), reviewed and updated the Index of Multiple Deprivation in 2004. The IMD 2004 is based on seven domains relating to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services domain, living environment deprivation domain crime domain. In the national Index of Multiple Deprivation, 2004, Manchester was ranked third in the country.

Ethnic group	Percentage of total population, Manchester	Percentage of total population, England
All White Groups (includes White British, White Irish, White Other)	81.0%	90.9%
All Mixed Groups (White and Black Caribbean, White and Black African, White and Asian and Other Mixed)	3.2%	1.3%
All Asian (Indian, Pakistani, Bangladeshi, Other Asian)	9.1%	4.6%
All Black (includes Black Caribbean, Black African,	4.5%	2.3%

⁸ Source: CACI and GMR, 1998.

⁹ Source: Regional Trends No. 38, 2004 © ONS

Other Black)		
Chinese and Other Ethnic Minority groups	2.2%	.9%

Manchester is Britain's third most diverse city, after London and Birmingham. South Asians are the most populous ethnic minority group in the city, making up 9% of its total population. One in eight of all Pakistanis living in England - and one in twelve of all Bangladeshis - live in the Greater Manchester area. Of its South Asian residents, Pakistanis are in a majority, followed by Indian and Bangladeshi (Commission for Racial Equality, 2007).

Ethnic group	Size of population
Pakistani	23,104
Indian	5,817
Bangladeshi	3,654
Other Asian	3,302

In the 2001 census, of all the households counted in the city, 41.8% were owner occupied (England average 67.7%). 56.4% of Pakistani, almost 50% of Indian and 48.5% of Bangladeshi households were owner-occupiers, which is higher than the average for the city. However, in the measure for occupancy rating, which is expressed in terms of rooms above or below the assumed requirement for a household, 24.4% of all Asian households (including 25.5% of Bangladeshi 24.1% of Pakistani and 32.9% of Other Asian households) lived in overcrowded conditions compared to only 11.2% of White households, and 18.7% of Black households.

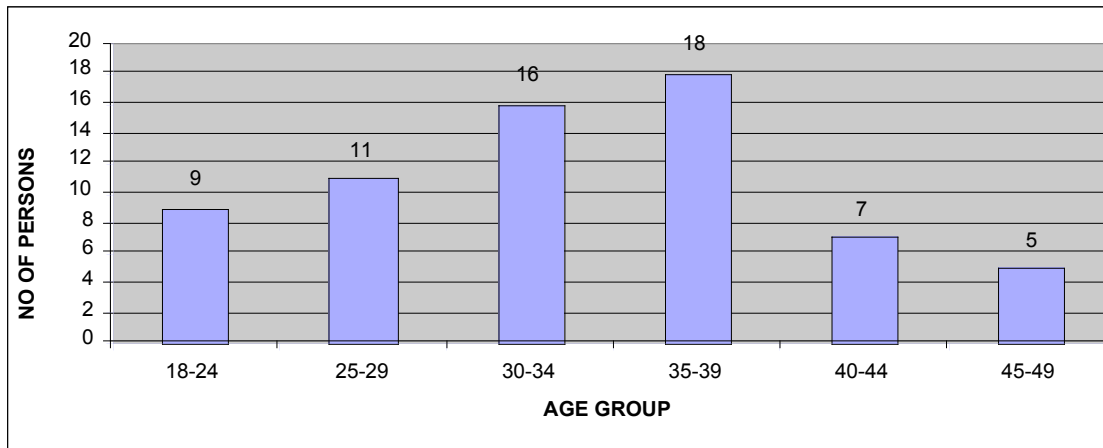
It is in this context of multiple deprivations that Saheli provides its services and it is the experiences of researchers and the women interviewed for this study in Manchester that has informed this research. Just as the process of this research cannot be separated from the social and political context in which it has been conducted, the aim of this research is to document South Asian women's experiences in order to bring about a change in policy and practice in Manchester, and from here in a wider national arena.

4.

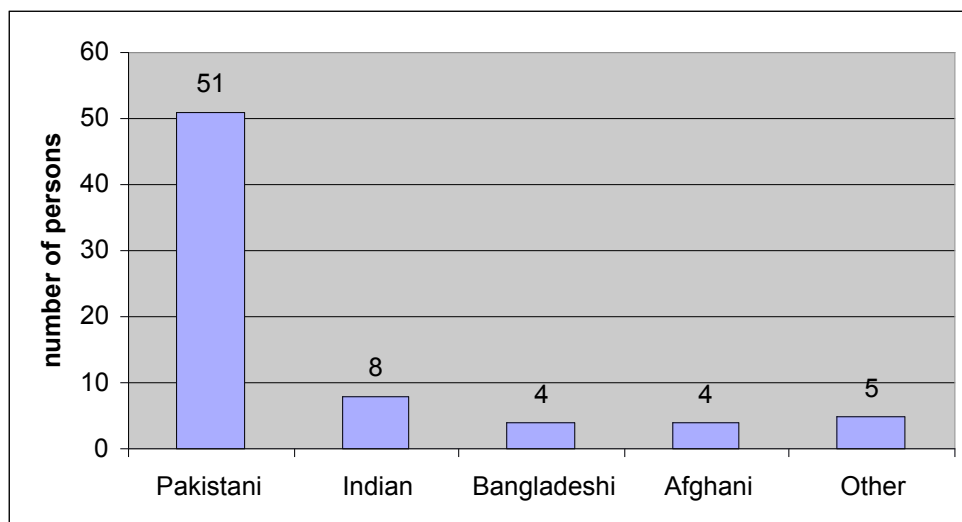
Findings

4.1 The characteristics of the sample

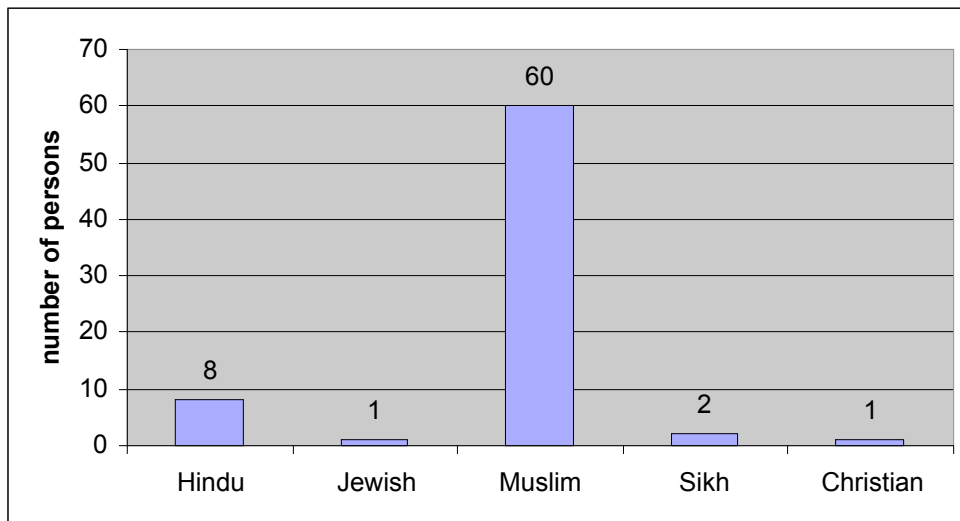
Age



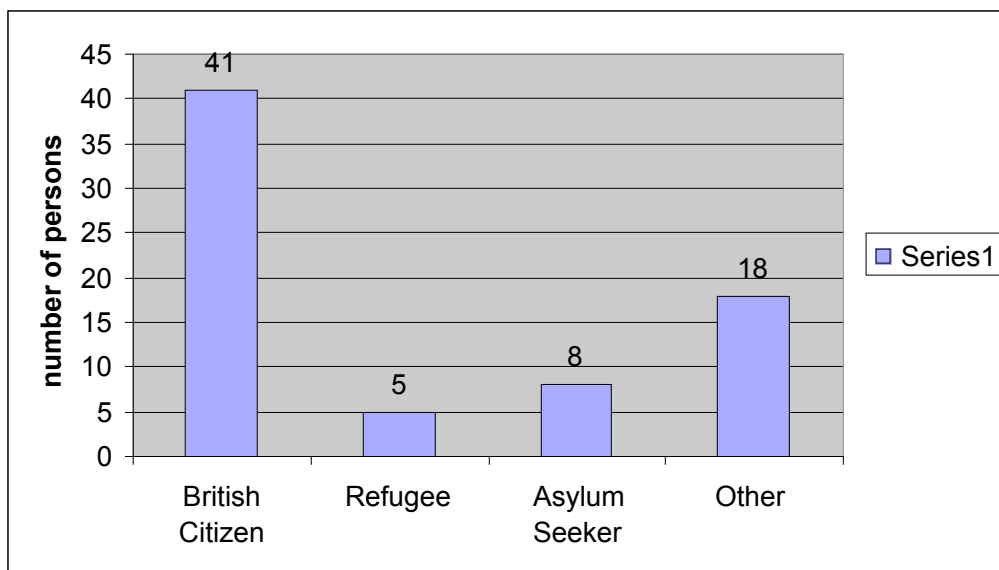
Ethnic origin



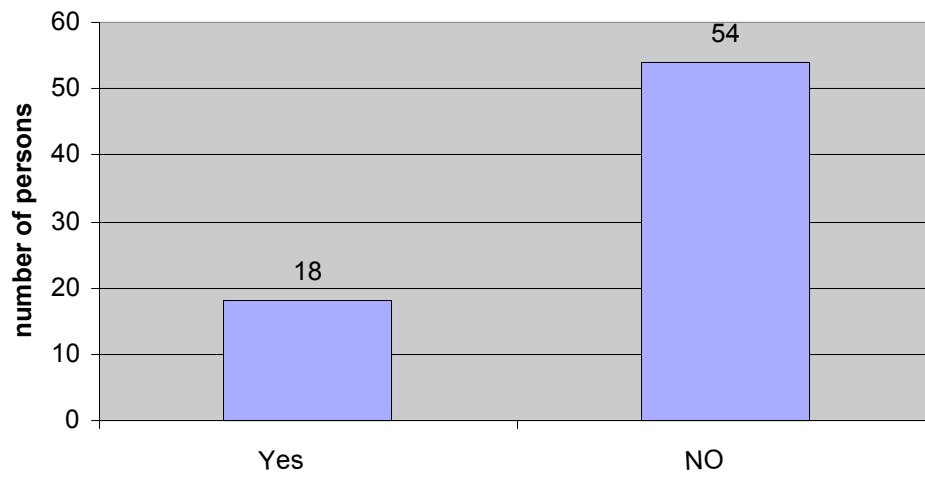
Religion



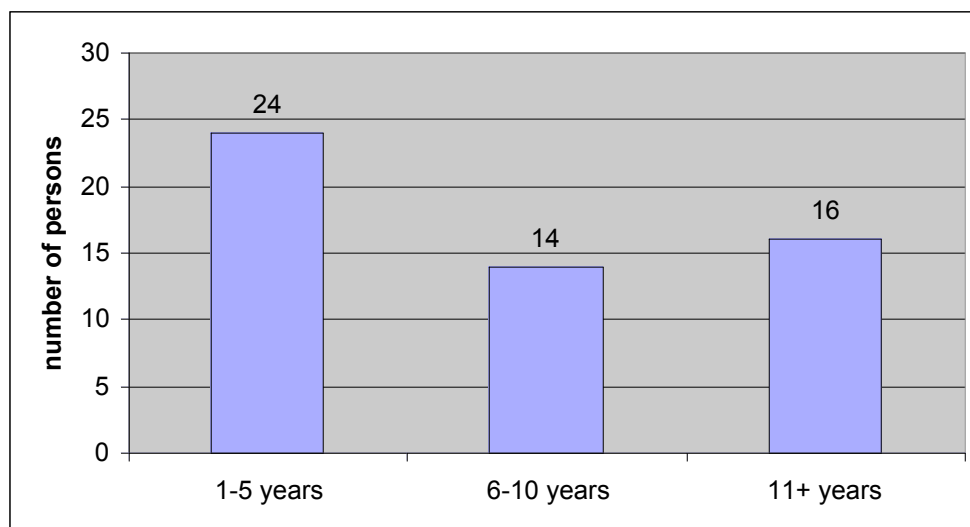
Citizenship



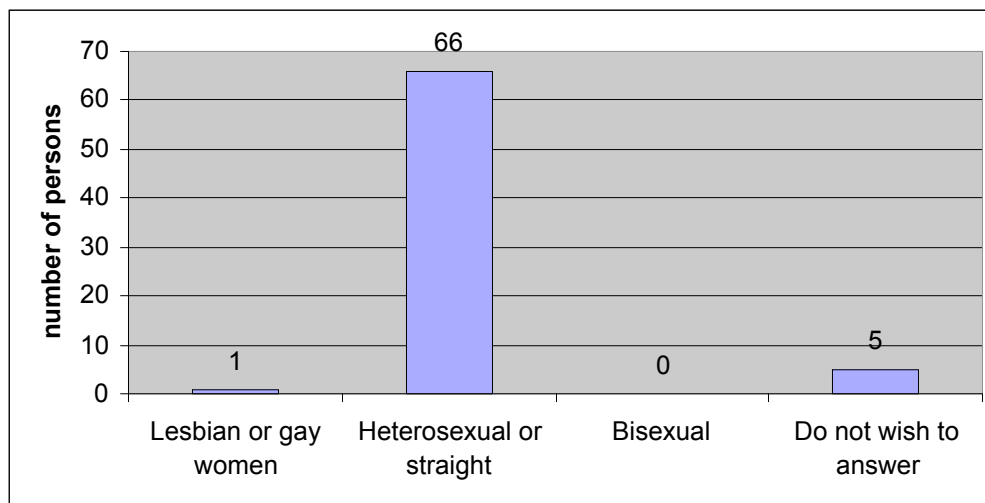
Were you born in the UK?



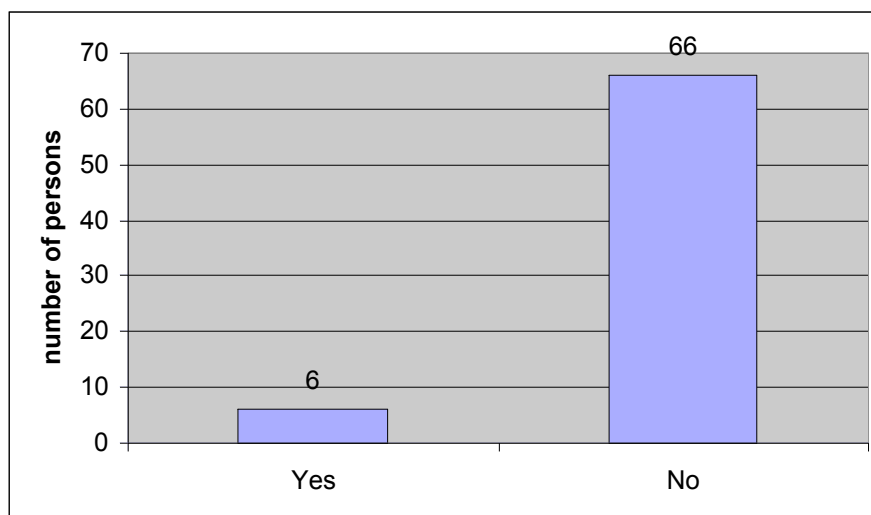
If you were not born in the UK, how long have you been in this country?



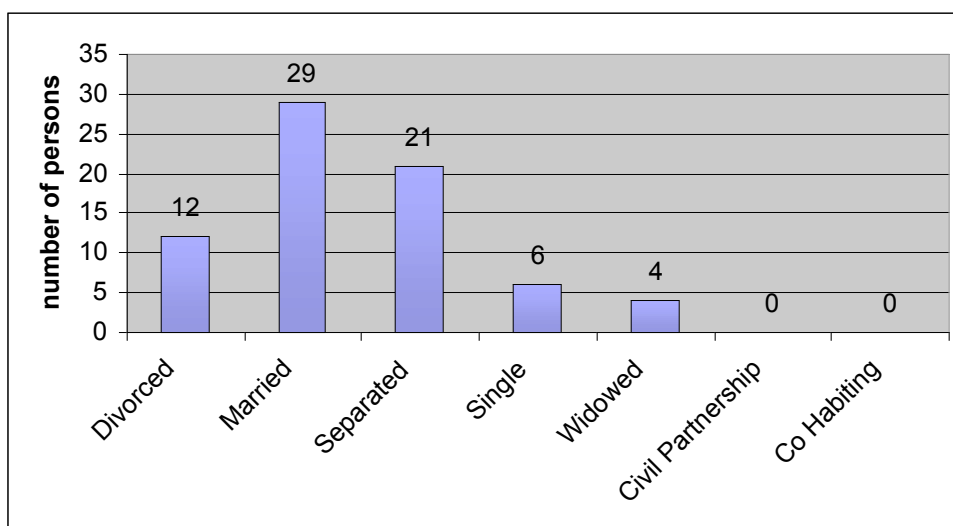
Sexuality



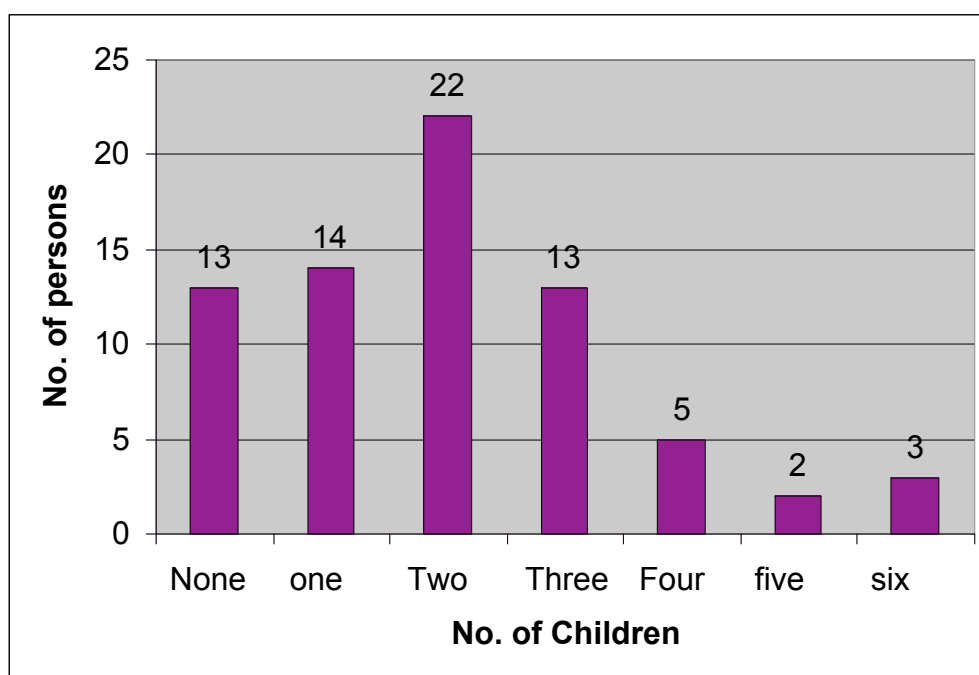
Do you have a disability or a long term illness?



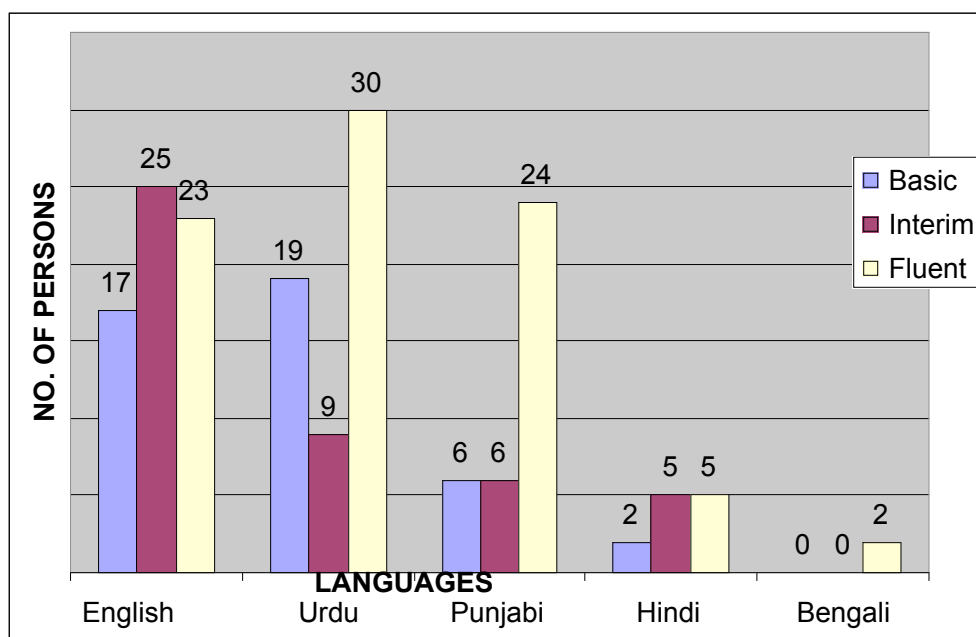
Marital status



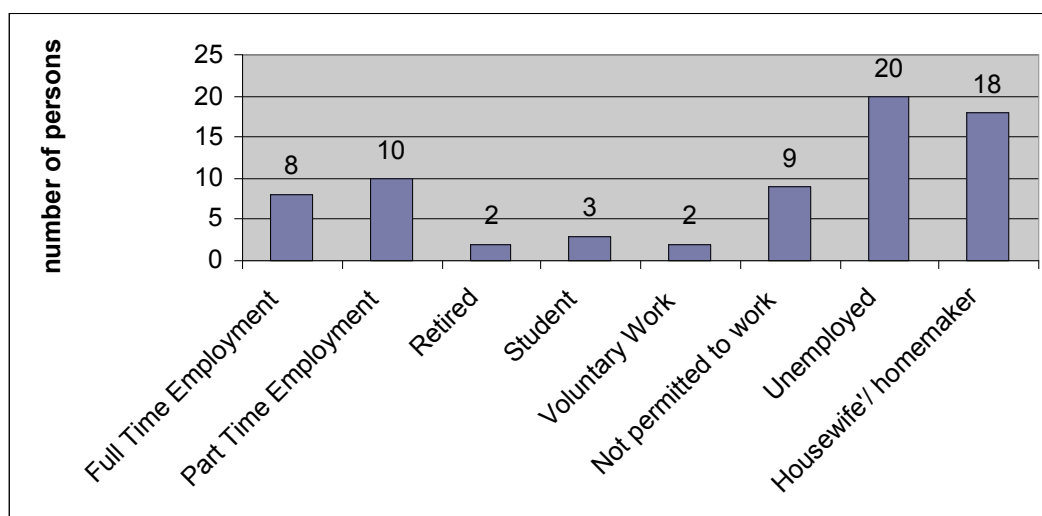
Number of children



Languages Spoken

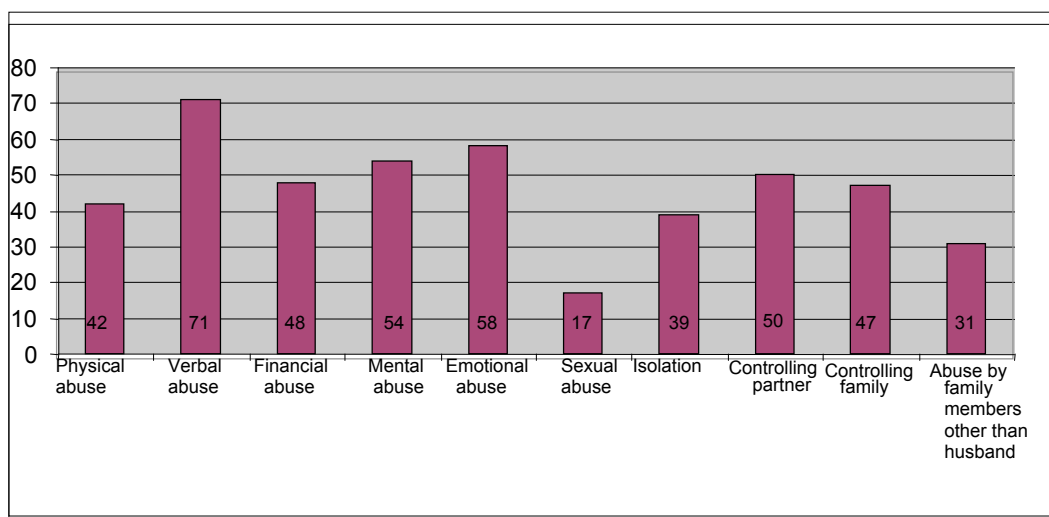


Employment Status

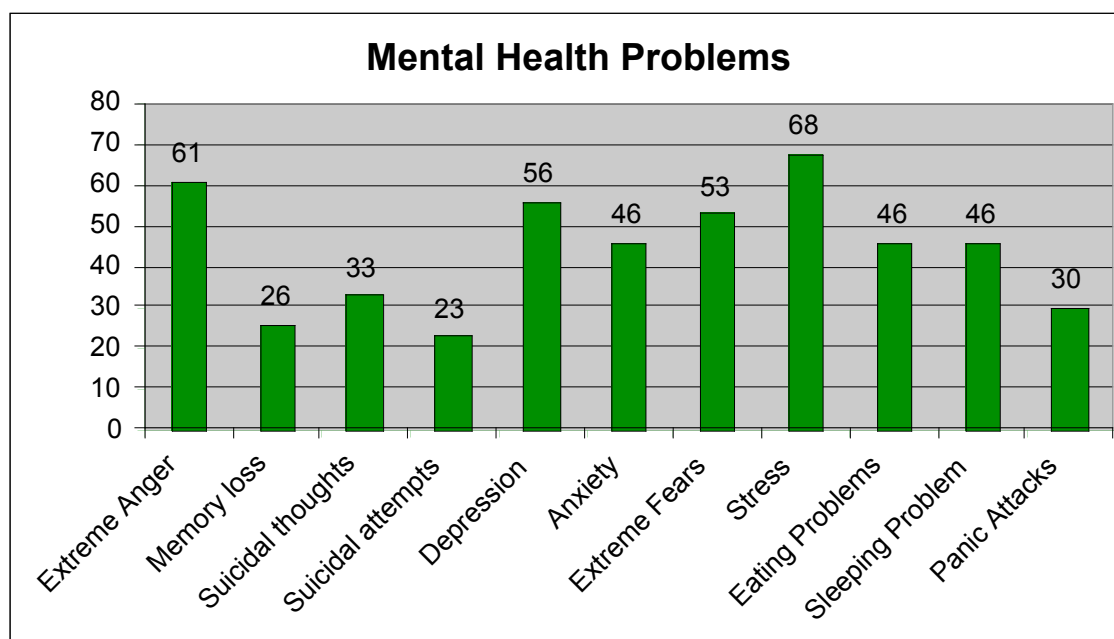


4.2 Domestic violence and emotional well being

Have you experienced any of the following?

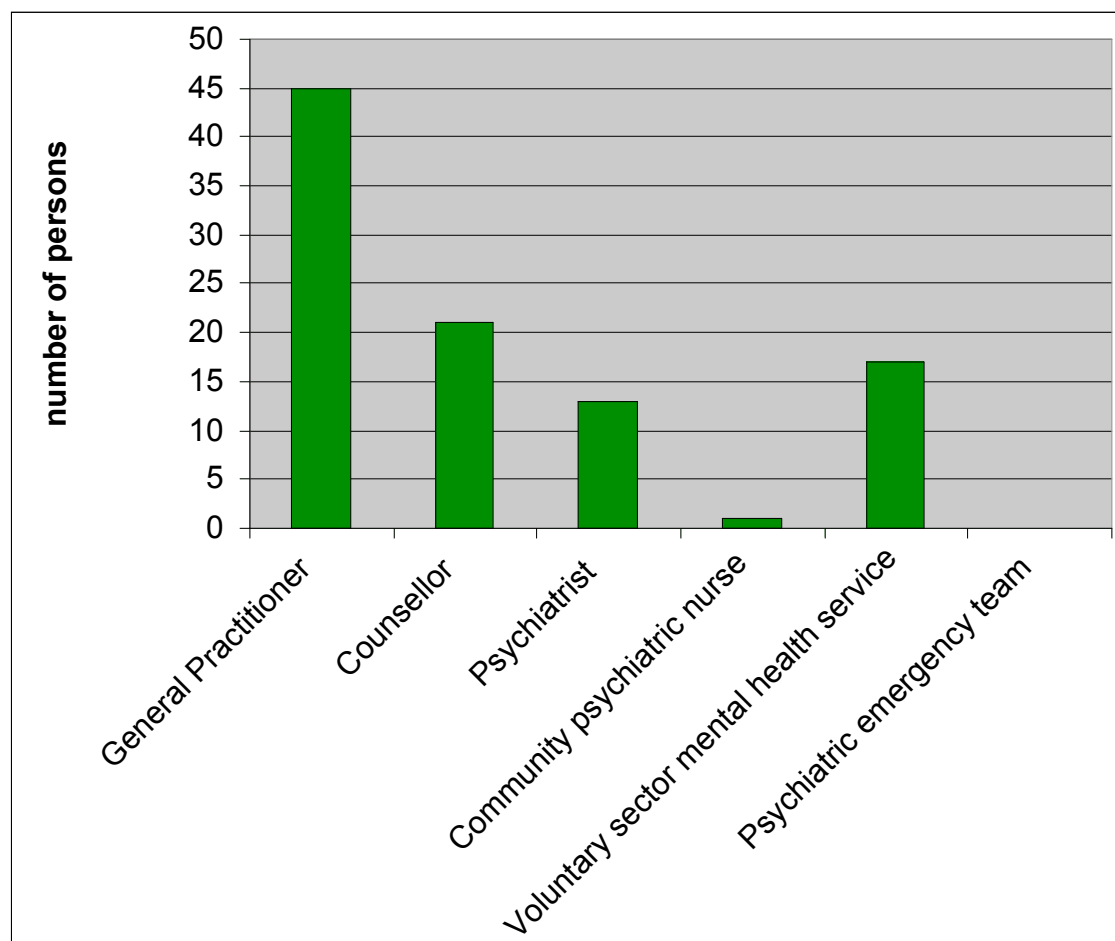


Have you experienced any of the following mental health problems?

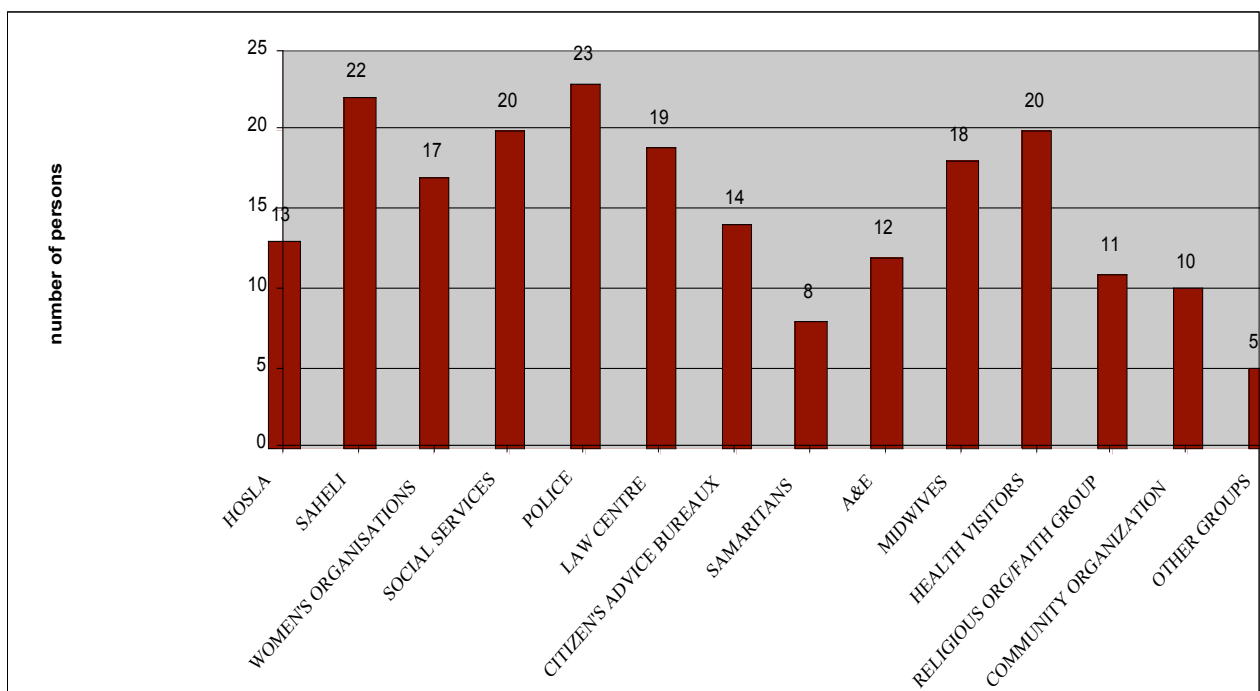


4.3 Support and services

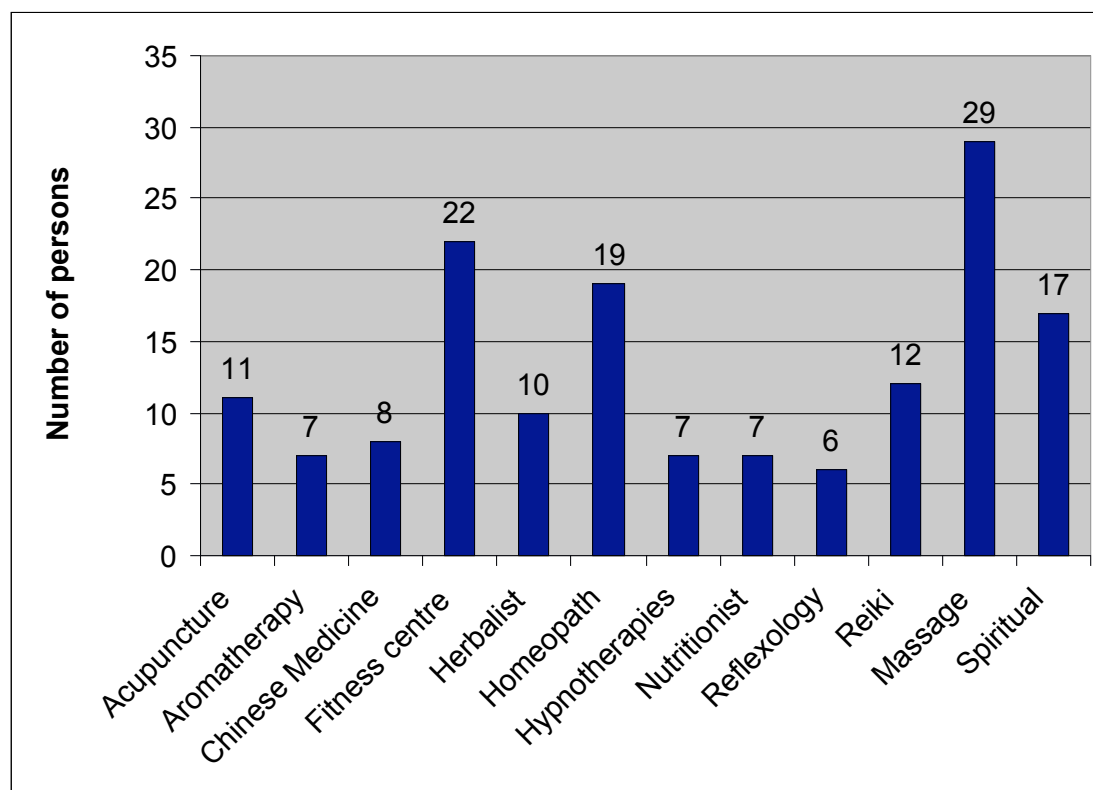
Have you used any of the following services to improve your mental well-being/ for help with your mental health problems?



Have you used any of the following services for help or support for the domestic violence you have faced?

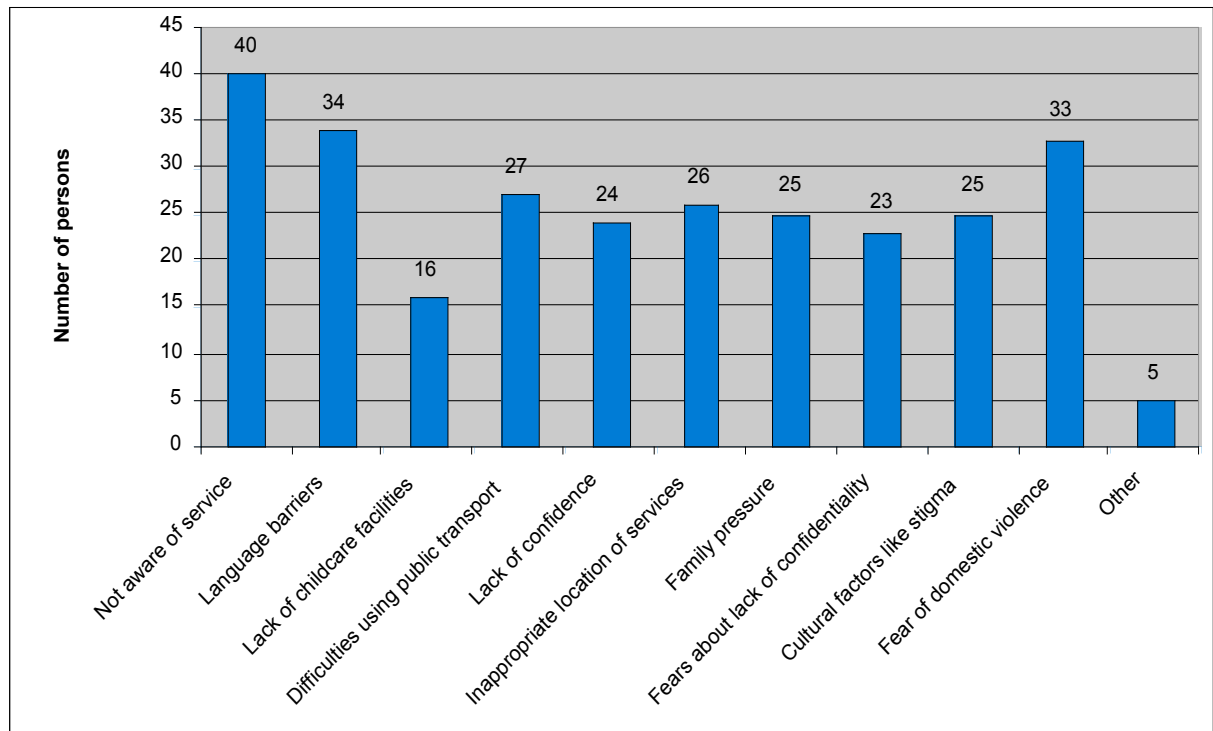


Have you used any of the following complementary therapies to improve your mental well-being?

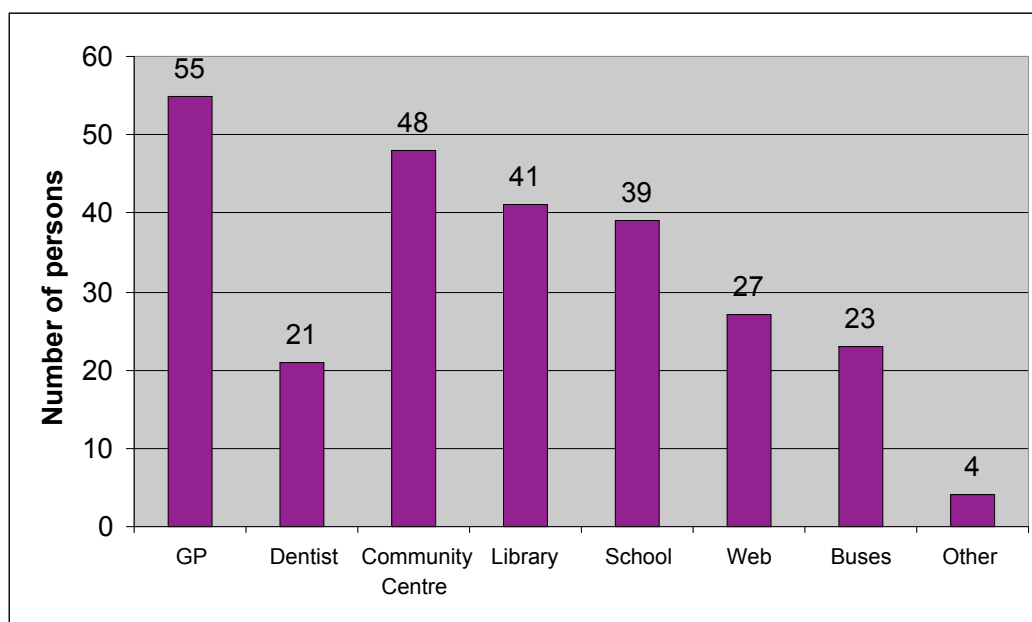


4.4 Recommendations

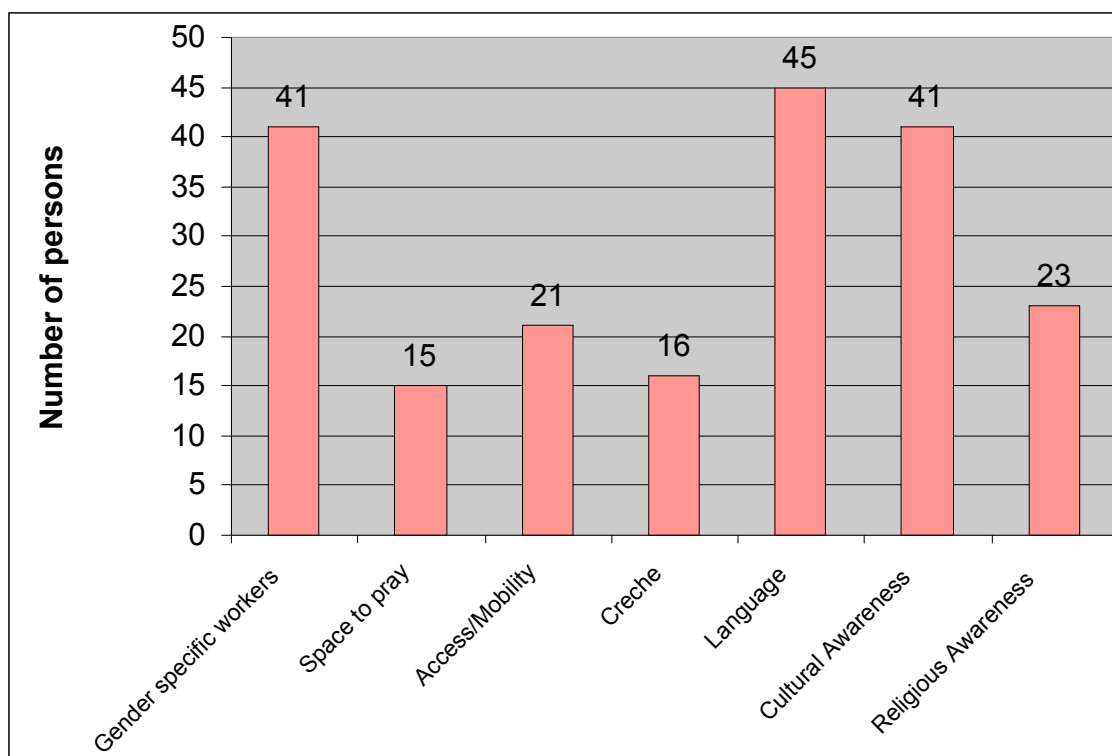
What are the three biggest barriers that prevent South Asian women from accessing a service?



Where would you like more information about services in your area displayed or made available to you?



Within an ideal service, what are the three things that you would most like to see?



5.1 The Sample

The first part of the interview explored the characteristics of the sample, in order to enable us to reflect on any gaps in the research and to analyse not just the particular findings with reference to the individual's context, but also explore the links between overall themes and the profile of the sample, if relevant.

Age

For this research, we interviewed South Asian women from the age of 18 onwards. This has meant that issues surrounding the domestic violence faced by young girls have not been fully explored in this research. This was because of the limited resources available for this project, the time constraints for this project and the lack of adequately trained researchers who could have conducted research with a younger group of women. Preliminary research evidence from the 18-24 year olds interviewed indicates that there remains an urgent need for further research on the domestic violence faced by younger women and girls, particularly, but not exclusively, in the context of forced marriage, and the mental health problems they face.

The demographic distribution of the South Asian women interviewed for this research reflects the profile of South Asian population in the UK, which has a younger age structure than white ethnic groups. Nine women interviewed for this research were between 18 and 24 years old, 52 women were between 25 and 44 years old, five were between 45 and 49 years old, and six were over 50 years old.

These low numbers of women over the age of 50 could be because while birth rates in Western European countries have fallen to a relatively low level, which means that the number of elderly people has been growing, and the number of young people has fallen, these characteristics are not shared by all ethnic groups. Taken together, all Asian groups had 3.8% pensionable age, compared to 15.25% of all white groups in the 2001 census.

While the high numbers of women between the ages of 25 and 44 reflects the demographic pattern of the South Asian communities in the UK, this could have been compounded by other factors. This was also the age profile of the researchers who interviewed women from their own community, which might have meant that they had better access to women who were closer to their own age. This age group is also most representative of those accessing services, and as many of the women interviewed for this research were accessed through domestic violence service providers and community organisations in Manchester it may also reflect their clientele.

Ethnic origin

The majority of women, 51 (70.8%) were Pakistani, 8 (11.1%) were Indian, while 4 each (5.6%) were Bangladeshi and Afghani. The category of 'other' (5 women) included 3 women of dual-heritage (White Irish and Pakistani, White British and Pakistani) and two women who had married South Asian men, lived and raised children within this culture for many years, and were included in this research since they identified themselves as 'South Asian' through their culture rather than ethnicity.

According to the 2001 census, out of all South Asian groups, Pakistanis were most numerous (64.4%), followed by Indians (16.2%), Bangladeshis (10.2%) and other Asians (9.2%). Pakistani women are slightly overrepresented in our sample, while Bangladeshis and Indians are underrepresented. The low numbers of Bangladeshi women can probably be attributed to the snowballing technique of sampling and the use of community researchers, all of whom happened to be of Pakistani origin and Muslim. Their initial point of call were the members of their community and through snowballing technique, the researchers came to know about other women who might be willing to participate in the research. In future research, it might be useful to recruit as diverse a group of researchers as possible.

Religion

The religious affiliation of the sample reflects the general pattern of distribution of the South Asian communities in Manchester in the 2001 census, where out of 35,880 people from all (South) Asian groups, 7.6% were Hindus, .1% Jewish, 77.8% Muslims and 4.3% Sikhs. Our sample consisted of 11.1% Hindus, 83.3% Muslims and 2.8% Sikhs. One person in our sample was Jewish, and one Christian, while 2.3% of South Asians in Manchester would come under these categories, and there is no one with no stated

religious affiliation in our sample whereas 1.3% of all South Asian groups come within this category in Manchester (Manchester City Council, 2004).

Citizenship

While a majority of our sample, 41 women (57%), were British citizens, 18 women (22.5%) had other nationalities, which included Indian, Pakistani, Bangladeshi and Afghani. A significant number, eight women (11%), were asylum seekers (including Afghani women who had spent some time as refugees in Pakistan), and five women were refugees. This is a high figure, and raises particular issues for agencies providing support to such women. These women who have no recourse to public funds have very little means of accessing support that is standard for other women in this country - they are denied access to refuge spaces and their immigration status may be dependent on the perpetrator of the violence.

Place of birth

A significant number, 54 women (75%) in our sample were born outside the UK, while 18 women (25%) were born in the UK. The duration of their stay in the UK was further explored for the 60 women through another question.

Length of stay in the UK

Of the 54 women who had not been born in the UK, a significant number - 24 women (44.4%) – had been in the UK for between 1 and 5 years, and 14 women (26%) had been here for between 6 to 10 years. 16 women (30%) had been in the UK for more than 11 years. Most of these women had come here following marriage, but a few had come as carers, or to join other family members. For women who had spent the least amount of time in the UK, lack of awareness of the construction of domestic violence as a social problem, lack of awareness of service provision, and language barriers remain some of the key issues that are further explored in this research.

Sexuality

Unsurprisingly, given the stigma attached to homosexuality among South Asian communities, 66 reported that they were heterosexual, none reported being bisexual, five women did not wish to answer this question, while one woman reported that she was a lesbian. The fact that the access to some of the women interviewed was through community organisations and domestic violence services, and the interviews conducted

through Saheli, a domestic violence service, may have provided a supportive environment where this woman felt safe to answer this question.

Disability

Six women (8.3%) out of 72 reported having a disability or long term illness, which included. This is close to the average for all people aged 16-74 in Manchester (10%), and much higher than the England average of 5.3%. However, these figures include 11% of men compared with 8% of women. According to Bendel et al. (2005), the proportion of people who were economically inactive due to permanent sickness or disability increases steadily up until retirement age (64 years for men, 59 years for women). Since a greater proportion of our sample are in the 24-44 age group, this figure of 8.3% seems to be above average for this age group and gender in Manchester.

Marital status

Of the 72 women interviewed, 29 were married and 10 were single of whom 4 women had been widowed. None of the women in our sample were co-habiting or were in a civil partnership, given the stigma attached to co-habitation. Twelve women were divorced and 21 separated, figures that seem particularly high and reflect the nature of our sample – a high proportion of women who had endured domestic violence and had managed to access services to leave the abusive relationship.

Number of children

13 women (18%), nearly half of whom were between 18 and 23 years old, did not have any children, and the remaining 59 women had between one and six children each. This has implications for the women's experience of domestic violence. Research indicates that domestic violence often starts or escalates during pregnancy (Burch and Gallup 2004; Jasinski 2004; Mezey and Bewley 1997), and following separation, perpetrator(s)' contact with children remains a dangerous time as well as a potential source of continued abuse for the women (Jaffe et al. 2003; Saunders and Barron 2003; Saunders 2004). For some South Asian women, the gender of the child has further bearing on their status and treatment within their family. There are also other implications for service provision, and issues surrounding the lack of childcare facilities, the lack of consideration given to the impact of domestic violence on children and the

potential of making information available through schools are some of the issues explored in the following sections.

Languages Spoken

The responses to this question supports the claims of language difficulties faced by South Asian women as documented in previous research (Thiara and Hussain 2005). Of the 72 women interviewed for this study, only 23 women were fluent in speaking English, while a further 25 reported intermediate skills in speaking the language.

Employment Status

Half the sample consisted of women who described themselves as ‘unemployed’ (20) and women who described themselves as ‘housewives’ (18). Eight women were engaged in full-time employment, while 10 women were working part-time and three women were students and two retired. Nine women were not permitted to work (or believed that they were not permitted to work)¹⁰, and 2 were volunteering.

5.2 Domestic violence and emotional well being: definitions, prevalence, perceptions

This section explores women’s definitions and experiences of domestic violence and draws upon interviews with 72 women to gain an understanding of the nature of the violence they have survived or are still experiencing. The concept of emotional wellbeing is unpacked by the women who also provide accounts of their experiences in relation to their mental health. Women’s narratives are the basis on which the relationship between their experiences of domestic violence and the mental health problems many of them were experiencing or had survived is examined.

Domestic violence: prevalence

Of the 72 women interviewed for this project, 31 women (43%) were still experiencing domestic violence at the time the interviews were conducted. Research suggests that between one in three and one in four women have experienced domestic violence at

¹⁰ Research with South Asian women who are recent migrants and have left the abusive relationship indicates that women are uncertain about their right to work due to a combination of factors like misinformation from the abusive partner, contradictory information from agencies and lack of awareness about their rights (Anitha, 2008).

some time in their life, and between 10% and 12% in any given year (Dominy and Radford 1996; McGibbon, Cooper and Kelly 1988; Mooney 1994; Radford, Hester and Pearson 1998). The findings of this study show that a larger proportion of South Asian women who have experienced domestic violence are still living within the abusive relationship.

This could indicate greater levels of disclosure about ongoing domestic violence, or that South Asian women in our sample face greater difficulties leaving abusive relationships. The definition of domestic violence employed in this study was a pattern of behaviour that includes physical, emotional, verbal, mental, financial and/ or sexual abuse, isolation and controlling behaviour by partner or other family members. While women's self-definitions are crucial to the process of naming their experiences, there has also been an attempt in this study to recognise and describe experiences which can be categorised as domestic violence, so that unnamed experiences of abuse do not come to be unrecognised (Kelly 1988: 137-43). The starting point of this research was to identify potential participants who were screened on the basis of this definition. In many cases, this process involved discussions between the researchers and the researched about the meanings of domestic violence, the cultural specificity of such meanings, and any disagreements regarding these recorded categories were noted, and inform the writing of this report. It is through this process that the 72 women who are part of this research sample were identified, and another eight interviews that were conducted were deemed unusable, as those women were not survivors of domestic violence. The use of community researchers, who were able to interview South Asian women in their own language, who had themselves experienced domestic violence, and were able to assure informants about the confidentiality might have encouraged women to disclose their experiences. Many women interviewed for this study spoke about the domestic violence they were facing or had faced for the first time. The experiences of women whose first language is not English may often be missed by studies which are not able to engage with the women in their own language. And the wide-ranging definition of domestic violence deployed may have yielded higher prevalence rates for ongoing abuse.

These figures could also indicate that there is a high prevalence of domestic violence among South Asian communities, as in the case of other groups of marriage migrants (Bui 2004; Raj and Silverman 2002). In the case of marriage migrants, the usual power imbalance between the woman and her husband, as well as between the two families in

South Asia and in the UK may be exacerbated. Her insecure immigration status, the lack of informal support systems for the woman in the UK as well as the lack of knowledge about services may also increase her vulnerability and the potential for exercising control over her at little cost to her husband and/or his family (Anitha 2008). There is a need for further research on the nature and prevalence of domestic violence among marriage migrants to the UK and its link to their experience of mental health problems. Of particular concern is the number of women who are currently experiencing domestic violence, of whom many were not aware of the service provision in their local area or Manchester.

Domestic violence: definitions and understandings

Women were also asked further questions about the nature of the abuse, its context, frequency and impact. A great depth of understanding was evident in the wide-ranging definition of domestic violence that was employed by the women interviewed in this study, which reflects aspects of the definitions that are currently being employed by the Home Office and organisations like Women's Aid, Southall Black Sisters and Saheli. The specific forms of abuse that women's narratives recounted included a continuum of a range of behaviour that was outlined by Pence (1987: 12) in the power and control wheel, as well as culturally specific forms of abuse, including forced marriage, honour crime, violence directed at women for not giving birth to sons and dowry related abuse (Patel 2000; Wilson 2006).

While many women mentioned physical and verbal abuse as a signifier of domestic violence, most women's understanding of domestic violence encompassed other forms of abuse such as emotional, mental, financial and sexual abuse.

"If a woman is hit by her husband and in-laws, if she is deprived of her basic rights, if she is suffering isolation because of her husband and in-laws, if she has financial problems because of them, then we should call it domestic violence."

Many women identified the perpetrator(s) as their partner and in many cases, his family members, while a few women also mentioned abuse from members of their birth family. This aspect of domestic violence does not always receive attention from service providers who often assume that the perpetrator is a women's partner or ex-partner.

South Asian women can experience domestic violence from a range of family members (Fernandez 1997). Within the dominant construction of ‘izzat’ in South Asian communities, women are burdened with upholding the family’s honour and their behaviour policed to prevent any deviation from the enforced norm (Gill 2004 and 2006; Patel 2000; Wilson 2006). Domestic violence occurs within this context to maintain these gender inequalities and to punish women who offer any resistance to them. Some young women interviewed for this study reported physical violence and emotional abuse in the context of a forced marriage, often to prevent the woman’s relationship with someone the family did not approve of.

“I have experienced domestic violence since I was 13 years of age. I had to marry my cousin from Pakistan whom I did not know. And if I said no, I would get the verbal, physical abuse.”

The government’s initiatives on forced marriage is almost exclusively centred on the overseas dimension of this problem, that is, the immigration of a spouse from South Asia as a consequence of forced marriage, which no doubt is a serious problem (Dustin and Phillips 2004). However, all South Asian women who face persuasion, emotional pressure, coercion and force as a form of control and exercise of power over their marriage decisions, need effective remedies, not just those whose case involves an ‘overseas dimension’. Service responses need to take into account the needs of all women facing domestic violence, not just those whose problems sit conveniently within other government agendas, such as immigration control.

Women’s experiences of violence in the home also transcended some traditional understandings of what constitutes domestic violence. One woman, who had experienced domestic violence from her family, had been given refuge in a stranger’s house, where she was exploited and faced further abuse.

“I came here five years back. My first year was alright, but after a year, when I did not give birth to child, my husband started abusing me and accusing me (of being infertile). He never took me for a medical check-up. I have no friends, no family members in this country. I was always locked up in my home... I was beaten up several times by my husband. After spending four

years in this situation I decided to leave him. I met an Asian woman and told her about my situation. She took me in ... but I faced so many problems there. I stayed for a year with this... family and they treated me like a slave. They were always blackmailing me... I used to do all their domestic work but that woman always abused me. I thought of killing myself many times.”

According to the definition currently employed by Home Office, her experience with the family who took her in would not be considered ‘domestic violence.’ However, many organisations like Women’s Aid employ broader definitions of domestic violence which take into account women’s experiences of abuse and exploitation in ‘family type relationships.’ This can be particularly true for women whose labour power is exploited and who are denied their basic human rights when living with their employers in ‘family-type relationships’ such as migrant domestic workers and au pairs (Kalayaan 2001) - professions where women far outnumber men due to gendered division of the labour market, with the ‘traditional’ women’s occupations like caring for children and domestic labour being worse paid and having little job security.

Several women mentioned the emotional abuse and controlling behaviour, and the fear associated with such a pattern of behaviour.

“Controlling you, taking away your freedom – when you can’t say what you want to, you can’t meet and talk to your family.”

These included being told that they were “stupid”, “ugly”, “lazy” or “worthless,” and frequent criticism, humiliation, ridicule and disregard for their emotions. Women described being made to feel that their sense of hurt and injustice, or anger at the way they were being treated, their feelings about the relationship and its problems were exaggerated or imaginary, such that you could not be confident in your own judgement. This attitude was exhibited both from the perpetrator(s) and often their own family and other relatives if they attempted to seek their help: the women *themselves* were found wanting, their behaviour was scrutinised and they were told to “adjust”, to “compromise” and to “sacrifice” to preserve the relationship, and thereby, the honour of the family.

“Whenever I complain about his attitude to my family, they take his side. They tell me to sacrifice, and he will change.”

Time and again, women interviewed for this research defined such behaviour as abusive and described the impact of such behaviour on their self-esteem and emotional well-being.

“I’m good enough to cook and clean at home but I can’t participate in making any decisions that affect my life – that is domestic violence.”

Most women had a prior familiarity with the concept of domestic violence, which they reflected on, as they answered subsequent questions. However, the interview and the questions about the nature of their experiences generated considerable discussion with some women who had hitherto not named their experiences as ‘domestic violence.’ This did not mean that they accepted what was happening to them, but that they were not aware that what they perceived as their (and other women’s) individual experience was constructed as a ‘social problem,’ which policies and service provision aimed to solve.

“My husband (is) always swearing and sometimes he beats me up... I did not know that this was ‘domestic violence’ till last year. I wanted shelter for my kids at that time... I just wanted to give time to my husband so he could think about what he wanted, what he was doing. I knew if he realised his mistake he must want us back, so at that time I went to temporary place for me and my kids.”

In this case, a chance encounter made the woman aware of service provision in this area, and she managed to leave the abusive situation for a few months. Even though she returned to the abusive relationship, she now redefines her experiences within this relationship as domestic violence, and is now aware of the service provision. This belies earlier understandings of women who ‘reconcile’ and return to their abusive relationship as passive and accepting towards the violence they experience (Gayford 1975; Pizzey and Shapiro 1982). This research shows, as has previous research (Mullender 1996; Dobash and Dobash 1992), that women actively assess their situation and the options

available to them with regard to support and services when they are in an abusive relationship. Leaving, returning and leaving are stages in this process through which women gain valuable experience and build up the knowledge and support systems that will enable many of them to leave forever.

Other women had similar experiences, and this process of naming their experiences generated a discussion between the researchers and the women interviewed. While this was sometimes true of domestic violence, it was particularly so with regard to sexual abuse, as some women were disclosing it, and naming it for the first time in their interviews. The extent of sexual abuse within marriage has only recently been recognised. Russell (1982) defined such abuse using the concept of a continuum, and Kelly (1988) explored how women experienced attitudes such as persuasion, pressure, coercion that exist within a dynamic of power imbalance between the couple such that the woman is not free to exercise true consent. A survey of 1000 women in city centres in North England found that 1 in 8 women reported having been raped by their husbands or partners, of whom 91% did not report it to the police (Painter 1991). It has only recently been recognised that victims of marital rape suffer many of the same reactions as other victims of rape, including very severe depression and suicidal tendencies (Council on Scientific Affairs 1992).

The responses of the women interviewed for this research ranged from anger, helplessness, fear and shame; what was common was an unequivocal understanding that the continuum of behaviour that they had experienced was abusive. However, their reticence in speaking about it stemmed from their understanding of dominant moral codes within their community and outside, which seldom validated their experiences. Feelings of shame and degradation, as well as the fear that their experiences of sexual abuse within marriage would not be believed or considered 'domestic violence' prevent women from all communities from talking about this form of abuse (Russell 1982; Kelly 1988).

"He used to have his way whether I wanted it or not...I was not allowed to say no... I did not know that this was considered domestic violence. I always felt bad afterwards...but I thought this is what happens in a marriage."

Similar concerns about stigma and the notion of ‘izzat’ as well as economic imperatives prevented many women from disclosing their experiences of sexual abuse within their families to service providers, often even after they had managed to leave.

“I come from a poor family in Pakistan. I had a relative here whose wife was suffering from (an illness). When he came to Pakistan with his wife, he came to my house and told my mother that he was looking for a carer for his wife. He asked if she would allow me to go with him as the carer. My mother agreed, so I came here to look after (her). She was always in bed, and one day, when I had finished all the housework and was cooking, (he) came and touched me in a bad way. I was really scared and did not know what to do. I could not tell (his wife)... he threatened me, that if I told her, he would send me back home. He used to send money to my family every week – they are very poor – and he told them that I was very happy here and that I have started attending college. I spent one and half years in this situation...I was abused every night, I often thought of killing myself.

I was not allowed to speak to anyone. One day, when he was not at home, I got a chance and told my neighbour everything. She was a kind woman and she advised me to leave the house. But I had nowhere to go to. After two weeks, she came and gave me some money and the address of her relative in Manchester. I ran away and came here. Now I am doing a part-time job and am also attending English classes.”

Another woman recounted the abuse she experienced at the hands of her stepfather:

“I was living with my family - mother, two brothers and step father. When I was 18, my stepfather raped me. My mother was working, my brothers are younger than me. I was so scared, I did not have a good relationship with my mom, I had nobody I could tell. When he realized that I had said nothing to anyone he did this again. Then I told my younger brother because I can talk to him openly. He

suggested that I should leave home. I left... without saying any word. Then I went to my friend's house and asked for help. She talked to some worker in a refuge, so I got a place after two weeks."

Where women have not felt able to disclose experiences of abuse, they have not had access mental health services to get specialist support, nor could they seek to redress the sense of anger and injustice they felt by exposing their perpetrator for fear of the shame this would bring upon *themselves*. Wilson (2006) examines how a combination of factors such as patriarchal notions of honour, the idea that women's sexuality is dangerous and the power inequalities between women and their abusers often makes women's individual battles against such oppression a lonely struggle.

Understanding of emotional well being

Women interviewed in this project consistently attributed emotional well being and mental health to the absence of inhibiting factors such as stress, fear, violence and abuse in their daily life and positive factors like confidence, self esteem and 'feeling relaxed' within their home.

"When someone can live independently, when you are totally relaxed. You eat well, sleep well. You have no fears from any other person. Nobody abuses you ...when you dress up nicely, treat yourself and look 'fresh'."

"Being able to live your life without constant criticism and without being hurt all the time, not feeling stressed all the time. Being able to enjoy and feel the small pleasures in life."

This understanding of mental health reflects their experience of domestic violence and the role of this violence in eroding their sense of self and self-esteem through controlling behaviour and abuse. Mental health and emotional well-being was defined by the women in this study as being free from abuse and its effects, particularly daily experience of stress and fear. Having a sense of self worth, feeling good about oneself, being able to live independently, and experience freedom in everyday life and decision

making were all signifiers of emotional well-being for many of the women interviewed. Some women articulated this direct connection between domestic violence and mental health problems by defining mental wellbeing as absence of the perpetrators of this violence.

“When I am away from my husband, I consider myself mentally well.”

“When I was living with my in-laws, I was unwell in my heart and mind. Since leaving them, I would say that I am mentally well.”

Experience of mental health problems

Most women interviewed for this research had experienced a range of mental health problems in the short or long term. These ranged from sleeping and eating difficulties, extreme fears, panic attacks, depression to suicidal thoughts, suicide attempts and self harm. Most women reported stress (68), depression (56) and extreme anger (61), a significant number of women also reported extreme fears (53), anxiety, eating and sleeping difficulties (46 each) and a significant proportion of the women reported panic attacks (30), memory loss (26). While 33 women reported suicidal thoughts, 23 women had made at least one suicide attempt, including women who reported incidents of self-harm. These figures indicate a high prevalence of a range of mental health problems among the women interviewed, and support the findings of previous research with South Asian women, which have also indicated that mental health problems, particularly depression, suicide, attempted suicide and self-harm affect a disproportionate number of South Asian women (Fenton and Sadiq, 1993).

Link between domestic violence and mental health:

‘its about being sad not being mad’

Women experience violence and abuse more commonly than often thought (Dominy and Radford 1996; McGibbon, Cooper and Kelly 1988; Mooney 1994; Radford, Hester and Pearson 1998). Research also indicates that histories of violence and abuse are common amongst women in touch with mental health services (DOH, 2003; Bowstead 2000, cited in Barron 2002; ReSisters 2002, cited in Barron 2002). Women interviewed for this project attributed a direct causal link between their mental health problems and the violence and abuse they were enduring or had survived. They did this in several ways.

Many women compared their mental health before they experienced violence and while they were living in an abusive relationship.

“My husband used to beat me up all the time, my in-laws always abused me. They treated me like a slave. I had no permission to go anywhere. I was also not allowed to attend phone calls. I suffered all this for two years... every single day. Before this violence, I was full of life, confident... But later, I lost my confidence, I was scared, mentally stressed. I always had a head ache... I could not do anything properly. I was always crying, and began to consider myself useless.”

“Before all this started, I...loved to dress up, loved nice food. When I was with my in-laws I was depressed... always wondering why I got married... why this has happened to me.”

Inability to trust in others, low self-esteem, inability to cope and make decisions, depression, detachment, anxiety, guilt, self-blame, shame, self-harm, suicidal thoughts, murderous thoughts, feelings of helplessness, eating disorders, insomnia, panic attacks, confusion - all these were mentioned by women as effects that enduring domestic violence had on them.

“I feel like being left alone. I lock myself in a room. Sometimes I leave the house and go for a walk. I have become less confident. My family has not been good to me (attempted forced marriage)... the situation at home has affected me a lot. I get all worried when my parents are together. My brother has started behaving like them too.”

“I have had a lot of problems with my husband and my in-laws ever since I got married. They want to be told everything and control me and my children. If I don't agree, I get shouted at, threatened and I feel he (husband) is going to hit me at any moment... If I try to do something that I like, I am not allowed to, and I feel very upset with this. I have tried to make my husband

and my in-laws try to understand but they don't listen or ignore me... I am not happy at home because of all the arguments. I am feeling very low, I am very anxious... I don't have confidence in myself. I don't look after myself and everything is an effort. This has been happening to me for some time now – more than a year.”

“I feel all alone. There is absolutely no one at home to talk to me. I used to stay awake all night, thinking about harming myself... That is domestic violence, when your family can make you become like this. The fights and violence at home has had a big effect on my mental well being. I have never been so angry or felt so helpless in my life...I put on lot of weight... I rate domestic violence as main cause of my mental state because my mind went almost out of control and I went into a depression after the incidents in my house. I am not happy at home because of all the arguments. I am still feeling very low and lack confidence, I am always anxious... I feel I have not been able to live my life; my husband and his family are all controlling me and I now feel low and emotionally drained.”

“I have often thought of taking my own life, I started to harm myself thinking I am not worthy of life. Even when I socialize, I feel as if I am on my own all the time. It's because I have suffered from beatings, verbal abuse and put-downs for three years now.”

For many women, the levels of severe emotional distress that they reported and attributed to their experience of abuse made recovery a long and arduous process. Some women spoke of the emotional distress caused by the abuse and the lasting impact that this had on their mental health.

“I felt like burning my house down with all the people in it. I was so angry. I felt like this for over two and half years. Even though I have left home, I still feel angry that this is a bad world, and my

sons will grow up and become bad people. I have always been afraid of (my) family when they are around. I had stopped eating, couldn't sleep, just sat all day and thought about what had happened in the past and what was going to happen in the future (possible forced marriage)...(I) was taking my anger on others, ...rowing with others, fighting with them... Everything in my life has changed because of domestic violence and being forced to marry someone at a very young age. My mental difficulties are directly related to, caused by domestic violence and being forced to leave home at young age of 17.

I was totally broken about all that happened with me especially when I was forced (by husband) to abort my first and second pregnancy. I was mentally and emotionally hurt, so much that I was depressed for a long time. The effect will last all my life."

"When I came into this country, my husband found a job for me... he used to take all my wages... I was not allowed to go anywhere. If I said I needed something, he would beat me up. I was not allowed to wear nice clothes, not allowed to put my make-up on. After finishing my job, I had to do domestic work. I had no time for myself. Whenever I wanted to talk to my parents in Pakistan he and his family used to start abusing me. I have lots of bruises on my body. I stopped eating but nobody bothered. When I was poorly, no one looked after me. I have lost weight, I can't sleep, that's why black circles appear around my eyes. I always look sick."

While some women who had left the abusive relationship described its impact in past tense, for others, their descriptions shaded into the present tense, and some women described how they felt that their experiences had scarred them for life. However, many women, especially those who had left the abusive relationship, and had managed to access support, spoke about the effects of the violence on their mental health and the process of recovery of their self worth and sense of emotional wellbeing. Their

experiences are discussed elsewhere, in the context of the services that they received this support from.

Impact of the domestic violence on children

While this research focussed on the women's experience of abuse and mental health problems, their children were ever present in their narratives. A recent research indicated that just above 1 in 4 young people reported physical violence between those caring for them during their childhood. For most, this was occasional or rare (21%) but for 5% it was constant or frequent (Cawson 2002: 37). Research indicates that children are often physically present during the violence, overhear it or witness the outcome (e.g crying, bruises etc.). There is also a recognised overlap between domestic violence and child abuse (Hester et al. 2000).

In this study, women's accounts of the abuse they endured also indicates their feelings of helplessness and their fear for the well-being of their children, and the impact of the controlling behaviour that was exhibited towards them as well as their children. In the case of the girl child, where the violence was directed at the woman for not giving birth to a male child, she was also fearful of her husband's and/or his family's attitude towards and treatment of her daughters. For some women, the trauma of enduring long term abuse also made the task of parenting a particularly fraught one. Though no specific questions were asked about the impact of the abuse on the children, some women spoke about the effect of the domestic violence on the physical and mental wellbeing of their children, and on their ability to care for, and enjoy their time with their children.

"I used to be badly beaten up by my husband. I could not tell anyone. I felt that my situation was not real, like it was in the movies...I was not allowed to go anywhere or speak to any outsiders. I was always tense and when I was beaten up, I used to hit my children. We (my children and I) had to live for days without eating. I felt I was going mad. I could not sleep. I lived in fear of my life. Before the violence, I was happy and normal."

"I was seventeen years old when I got married to my cousin in Pakistan. After two years, he came here and after another two

years, I gave birth to a daughter. He was happy then, but after another two years when I gave birth to our second daughter, he started fighting with me because I had not given birth to a boy. When I was pregnant again, I was very worried and scared. But I had another baby girl. My husband began blaming me when it is not my fault. It's not in my hands, and I was very emotionally hurt by his behaviour. I have experienced fear from my own people, and hate from my parents. When I complained to my parents, they told me that I was to blame...I feel anger towards my own children, towards him and my family...my stress and depression is totally because of his behaviour, his violence. Even so, sometimes I blame myself – it might be my fault. His violence gives me so many negative thoughts.”

There is no standard response to living with domestic violence and all children may react differently; children may experience a wide range of short or long term physical, emotional, behavioural and social problems as a result the violence directed at them or the distress caused by the abuse of their mother (Hague et al. 2002; Kahn and Hall 2003; Kendall-Tackett 2005; Lundy and Grossman 2005; McGee 2000). Some children recover well once they feel safe (Mullender et al. 2002). However, there are other children for whom the effects may be more long-term, depending on factors like their coping strategies, sources of support or age. The lack of support for children who have witnessed abuse remains a key issue despite the recent recognition of the harm done to children as a consequence witnessing the abuse of a loved one (Hester et al. 2000; Lundy and Grossman 2005; McGee 2000; Mullender et al. 2002; Mullender 2004). The Adoption and Children Act 2002 extended the definition of ‘significant harm’ within the Children Act 1989 to include ‘impairment suffered from seeing or hearing the ill-treatment of another’. However, service provision continues to remain patchy.

“My youngest child was five years old when all this was happening. He could not sleep. I had to give him medicines to get him to sleep.”

Three women disclosed their current experiences of domestic violence but stated that they did not let it affect their mental well-being. Two of them had experienced

domestic violence over decades, and the physical violence they had endured earlier had been replaced by other means of exerting control like verbal and emotional abuse. The perspectives expressed by these women reiterates dominant attitudes towards domestic violence as a ‘private’ matter, poses women’s responses to the violence rather than the violence itself as problematic, and emphasises the transformative potential of women’s ‘sacrifice’.

“Such things happen in all relationships – it does not mean that you take it to heart and break up the family.”

But these responses were rare, and most women indicated that the domestic violence they had survived or were enduring had profound, pervasive and direct impact on their mental well-being, and welcomed effective policy responses to the problem – even where they themselves did not feel able to follow the options through and leave the abusive relationship at that point in time. It is these policy responses and service provision that we shall now examine.

5.3 Women’s experiences of formal sources of support and services

This section explores women’s experiences of services that they have contacted for help, advice and support regarding the domestic violence and the mental health problems they have experienced. Research indicates that women’s initial efforts are often geared towards managing the trauma of abuse by focusing on the symptoms in an attempt to alleviate some of it, and far from being passive and helpless victims, they may make partial disclosures, resort to constrained help-seeking without naming the problem, test service responses and confidentiality. And over time, women often make full disclosures to seek help from informal support systems and from a variety of services – often again and again (Dobash et al. 1985; Pahl 1985; Hoff 1990; Kelly 1988: 159-195; Mullender 1996).

This research explores women’s experiences with, perspectives on and recommendations regarding mental health services, complementary therapies and domestic violence services. This research also seeks to examine whether services respond holistically to the needs articulated by women who access them. Given the causal and pervasive link between domestic violence and mental health problems that has been articulated by most

women in this study, this section also examines to what extent organisations identify, engage with, and respond to the cross-sectoral issues: domestic violence services to women's mental health problems, mental health services to women's experience of abuse, and complementary therapy services to both mental health problems and domestic violence that women face.

Women make their way to services through a variety of routes. In the case of counselling, many women accessed this service in a healthcare setting, while some women received counselling in a somewhat different context - through a voluntary mental health organisation where they had been referred to by a domestic violence service. For some women, contact with social services was following an explicit disclosure of domestic violence, whereas for some women, this referral may have come about following concerns about child welfare or diagnosis of mental health problems, or both. How women's experiences are labelled may have implications for the responses they receive from the services.

Services contacted for help with mental health problems

The first part of this section explores South Asian women's experiences of accessing services for support and advice in relation to their mental health. These include a wide range of NHS mental health services, General Practitioners and voluntary sector mental health services. Women were initially asked which services they had contacted in order to improve their mental well being. The women responded from a list of possible services, and were also asked if they had contacted a service not on the list. Subsequent questions explored the nature of this contact, when it was first made, the number of times women accessed the service and their experiences.

General Practitioners (GPs)

Research indicates that GPs are often the first port of call for women who are experiencing domestic violence and mental health problems (Dobash and Dobash 1979; Dobash et al. 1985: 148). An American study of the use of the health service by domestic violence survivors found that 18% go to a physician in the first year of abuse, 56% in the second year and 31% during the third year (Refuge, undated).

In this study, a total of 45 out of the 72 women who had experienced or were experiencing domestic violence had contacted their GP, many of them several times, to seek help to improve their mental well being. These women presented with a variety of symptoms like headaches, weight loss, loss of appetite, sleeplessness, anxiety, panic attacks, restlessness, and depression – all symptoms they attributed to their experience of domestic violence, a link they seldom initially articulated to their GP. Research indicates that most women do not mention the possibility of domestic violence directly when they seek help from health services (Mehta and Dandrea 1988; Mullender 1996; Pahl 1985; Strube 1988). Dobash and Dobash (1979) estimated that only a quarter of women seeking medical help actually reveal that they have been physically abused. Research demonstrates that when women seek help, they do so in a “tentative and ambivalent manner, filtered through shame, self-blame, concerns about exposing their private problems to strangers, fear associated with the consequences if they are found out, and concerns about the nature of the response they might receive” (Dobash and Dobash 1992: 232). The general practitioner’s response to a woman's first tentative attempt to seek help can make an immense difference to that woman's life and those of her children (Richardson and Feder 1997).

Seven of the 45 women who contacted their GP were prescribed ‘tablets’ – a recurring phrase which further questioning failed to illuminate. Some of these women described their distress at the symptoms brought on by these drugs, especially difficulty concentrating, drowsiness, confusion and lethargy, and some women reported that they had discontinued the medication. The side effects of the medication indicate that some of them were possibly tranquilisers. None of these seven women had been told about the nature of the medicine, its side effects and the reasons they were being prescribed these medicines, that is, how the medication related to their symptoms of mental health problems, neither had they been referred on to a mental health team.

“I saw a doctor, because I only know about doctors. ... my doctor’s behaviour was not good... only medicine is not enough for treatment.”

When women are prescribed medication without being given all the relevant information to enable them to make a decision about its appropriateness, they are yet again placed in a situation where decisions about their lives seem to be made without reference to their

wishes. Absence of prior information can also make the side effects of some of this medication difficult to handle.

“I went to my GP because I was depressed. There was a lot of pressure on me; my children were also affected (by the violence). I was very upset as I was not allowed to go outside or make any decisions... I used to cry all the time. I was prescribed sleeping tablets. After that, I felt as if my brain was sleeping all the time. I was not really satisfied because I did not feel that the medicine was working. I was still worried and depressed, and my children were still disturbed because of our situation. I was always stressed.”

“The doctor gave me tablets for depression, but after using it I used to feel so drowsy that I got scared and I decided not to use them again.”

In one study, a total of 180 British South Asian women were sampled to pilot test an educational pamphlet about depression and ‘suicidality’. After reading the pamphlet, significantly more women assessed themselves as willing to confide in their clinicians, friends, and spouses if they felt depressed or suicidal, rather than not telling anyone. Also, more women reported that they felt that antidepressants were helpful for depression after they read the pamphlet. These changes remained four to six weeks later. The pamphlet was feasible for use in primary care and community settings and highly acceptable among both British South Asian women and professionals (Bhugra and Hicks 2004). Information that is provided in an accessible manner can enable women to understand their diagnosis and engage better with their physicians.

However, in the case of domestic violence the prescription of medication does not address the root cause of their problems. In fact, tranquilliser use is contra-indicated for domestic violence because the woman is not sick but is exhibiting a normal response to abnormal events like long-term trauma and life threatening circumstances. The side effects of the medication may inhibit safety planning, and these drugs are only effective in the short term, whereas abuse is a long-term problem (Mullender 1996: 113). The

effectiveness of many of these tranquillisers often decrease over time, while the underlying causes of the symptoms may remain or escalate over time.

“The GP gave me some tablets which I took regularly and it seemed to help with my depression, anxiety... and sleeplessness. But then after some time it started to have less and less effect. And he stopped it. Now I don’t get any medicines for my problems. My problem is still the same, but they cannot understand my situation.”

Other women were given medication that addressed their surface symptoms such as painkillers (in the case of 8 women), sleeping pills (prescribed to 5 women) and one woman was prescribed appetite improver for weight loss brought on by depression, stress and anxiety, which in turn was caused by the experience of domestic violence. This tendency of general practitioners to address the symptoms without interrogating the causes has been documented in previous research (Mullender 1996: 112-5), and remains a persistent complaint of women who have experienced domestic violence and have approached GPs.

“I visited the GP several times, often with my husband, because of my weight loss...and was given medicines to improve my appetite.”

“My GP only gave me paracetamol, which did not have any effect. I am not happy with them. They should send me to specialists so I can get proper treatment.”

“I saw my GP because it was not easy to see anyone else (other services). But I could not tell him everything about my problem. I told him about the headaches and got some tablets for it.”

“I contacted my GP several times over the last 5 years. However, because of family pressure, I could not tell him the real problem, and was making do with sleeping tablets.”

Three women reported responses from their GPs that showed a complete lack of understanding of their experiences, the nature of domestic violence, the causes of their mental health problems and the constraints women live by when subjected to unrelenting control and abuse.

“After my husband died, I suffered a lot at the hands of my in-laws. I was worried about how to feed my children. I was depressed, having trouble eating, sleeping...I used to go to my GP every two-three weeks... I was only given some medicines and sent back. My GP advised me to be happy, not to worry and to share my worries with others. What could I say to that? They should understand our problems and should try to help us.”

“I see my GP every 2-3 weeks. My GP has advised me to go to an open space for peace of mind.”

“My GP said that I should try to relax... go for long walks – I could not even go to the shops without permission.”

At the very least, these suggestions indicate a lack of engagement with the women's mental health problems, a failure to take their perspectives and experiences seriously. At the worst, they indicate collusion with dominant perspectives on domestic violence – that the problem lies in the woman's responses to the violence, and not in the violence itself. Hence the solution centres on modifying her behaviour or response without engaging with causes and without validating her experiences. It is no wonder that the women who encountered these responses indicated their dissatisfaction with the advice they were given.

“They don't understand what you are going through, and you feel so low that you don't have the energy to argue with them.”

For some women, contact with their GP was a positive experience. This was mostly where their concerns and symptoms had been taken seriously, they had been referred to mental health teams, the GP had continued to engage with the context of their mental health problems by being pro-active in unravelling the link between their mental health

problems and domestic violence, they had been offered advice and information about domestic violence services in the community, referred to specialist mental health teams, and/or offered ongoing emotional support. Pahl (1985) also reports a satisfaction with GPs where the service provided by them extends beyond purely medical concerns. Of the 45 women who contacted their GP, six women reported an integrated response that addressed all or most of the aspects discussed above, while 7 women were referred to mental health teams without engaging with the domestic violence which they perceived as the cause of their mental health problems. They had varying levels of satisfaction depending on their experience, discussed later.

“My son supported me and gave me the confidence to speak to my GP. My doctor referred me to a counsellor. He suggested that I could leave home and also gave me addresses of services I could contact. My GP has been very attentive, caring and supportive – I have gone to him several times since then.”

“After (experiencing domestic violence for) a year, I contacted my GP about two months back. She gave me a lot of help and advice – I feel good knowing that there is some support out there, but I have noticed that it is not much (for women with no recourse to public funds).”

Some women's fears about approaching agencies for support, especially for mental health problems, may limit their chances of receiving safe and appropriate interventions. Research indicates that this fear is caused by several factors like lack of knowledge of existing agencies; fear that they will be sectioned; concern that their children will be taken into care; fears that this will label them as being 'mad' when the perpetrator of the violence may be using similar labels to undermine their notions of the self; and uncertainty about service responses or their confidentiality (Hoff 1990; Mullender 1996). Partial disclosure may be another tactic women use in order to receive some treatment but protect themselves against unwanted interventions.

On the whole, the GPs often treated the symptoms and did not pursue the causes, thereby making inappropriate diagnosis. Dobash and Dobash (1980: 183) documented that 75% of general practitioners treated physical injuries but not ask questions about their origins,

thereby colluding with the continuing concealment of domestic violence. Though the figures may have improved for physical injuries following several guidelines for practitioners and a greater awareness of some issues surrounding domestic violence, the situation continues with regard to mental health problems caused by the experience of domestic violence. When abuse is either disclosed or suspected among patients, proactive asking about domestic violence was usually dependent on individual judgement, the existing relationship between practitioners and victim and the perceived severity of the abuse.

In research conducted by Worms (2004), only two out of 15 PCTs in the Thames Valley region had any form of routine screening, which had been started as part of health visitor checks. A research testing the effectiveness of an intensive intervention to improve routine screening about domestic violence, which involved skill training for providers and environmental orchestration (posters in clinical areas, domestic violence questions on health questionnaires) revealed that case finding increased 1.3-fold (Thompson et al. 2000). Research also indicates that pro-active screening can also enable earlier intervention and that the majority of victims would have welcomed being asked, even if they were unable to follow the referrals through at that point in time (Worms 2004). Research has highlighted the concerns physicians express regarding routine screening for domestic violence (Sugg and Inui 1992). However, in a pilot study conducted at GPs surgeries by Westmarland et al. (2004), few patients (7% of women and 13% of men) said that they would feel offended if their GP asked them about domestic violence and the GPs generally expressed more concerns about asking about domestic violence than the patients actually had. Training resulted in attitudinal changes among GPs and dispelled myths about domestic violence.

The 1989 Home Office Research Study on Domestic Violence (Smith 1989) and a subsequent editorial in the British Medical Journal (McIlwaine 1989) highlighted the need for the medical profession to develop codes of good practice in relation to domestic violence. There have been other guidelines in relation to the care of women who have been subjected to domestic violence and who present to general practitioners and other health workers in the UK primary health care setting (Heath, undated). However, these guidelines are not being consistently applied, leaving many women and children with little means to access the appropriate support and leave abusive relationships.

NHS Mental health services: counsellors and psychiatrists

Of the 45 women who accessed their GP for their mental health problems, 13 were referred to a specialist mental health team, with nine referrals to a counsellor, and four to a counsellor and a psychiatrist. For six of them, these referrals were a part of a multi-agency response that addressed the issue of domestic violence. Not all of them were able to take up the referrals because of factors like the fear of further violence, lack of childcare facilities and the stigma associated with mental health problems. The experiences of women with the mental health service varied depending on the level of engagement with the causes of their mental health problems, the accessibility of the service, the ability of the service to cater to women's language needs and the level of cultural understanding.

Lack of awareness of women's contexts (cultural and material circumstances, as well as the particular context of domestic violence), fear of contributing to essentialist attitudes towards their communities through a discussion of the violence they were facing and language barriers were the most cited reasons why women could not benefit from these services. While some women referred to the difficulty of discussing such taboo subjects, their very presence at the counselling session indicates that greater confidence in the cultural competence of the counsellors/psychiatrists' ability to overcome the cultural/language barrier might have resulted in greater disclosure rates:

"When I was low, depressed, I went to see the GP...a few times. My doctor referred me to a counsellor and offered me the medicine Prozac, which I did not want to take as I had heard that it can become addictive. I did not feel comfortable with the counsellor...I just was not able to connect to her and felt very uncomfortable after ten minutes with her...I just wanted to leave the room. The whole atmosphere was very formal. I don't know, I felt very uncomfortable...I suppose I would have benefited from an Asian counsellor... someone who could understand how it is in Asian families. The shame of these issues makes it very difficult to talk about it."

“I used the services of a counsellor only once. She did not give me much help because I could not understand what she was saying... I was not able to answer her questions properly.”

Four women, particularly those who had no difficulties communicating in English, reported positive experiences with counsellors and psychiatrists in the health services.

“When I ended up in hospital, the nurse who was looking after me referred me to the services... and they said that they are going to refer me to a Community Psychiatric Nurse who will come and see me at the refuge. She gave me the loads of bits and bobs to think about like the kind of help I can get.”

“They (husband and his family) made me feel worthless as a person – I have suffered from panic attacks for over three years now. I went to my GP and was referred to a counsellor and psychiatrist. I saw the counsellor every week and was satisfied with her. It provided me with a knowledge and understanding of my situation. However, the time I was given was not enough.”

Voluntary sector mental health services

Seventeen women had contacted Voluntary sector mental health services for help or support after hearing about the services through their informal networks or had been referred to them through South Asian domestic violence services.

“I found out about the counsellor through a refuge I was in – this was the first time I had contacted them (Roby). When I phoned, they accepted me straightaway and are really helping me to reach my goals. I have received a lot of help. They understand my culture and religion and can see where I am coming from. It was easy for me to talk to them. I could sit down and just talk about what I had been through for the first time, and they would just listen and give me ideas to think about and tell me about the support they can give. It really helped my mental wellbeing.”

“My life was in danger and I was in a desperate situation. The help I received saved my life and that of my children and now we are safe. This took all my tension away. I did not know anything about where to go and how to find a place to stay. When they (Saheli) told me that they would help me, I felt mentally better and was less scared to face life alone. At Saheli, they told me about Roby project, and I saw the student counsellor.”

“When my life became very difficult after my husband died, I went to Roby every week for about three and half years – their worker was very good. She always listened to me.”

Women who accessed voluntary sector mental health services overwhelmingly reported feeling that they were being listened to and their experiences validated. While cultural understanding and absence of language barriers was a significant factor in their positive experiences, what was crucial was also an engagement with the context of abuse without essentialising their communities as inherently patriarchal. In the case of Roby, this heightened awareness of and understanding of the links between mental health problems and domestic violence can be attributed to their close work with Saheli over the years. This partnership working and cross-referrals between Roby and Saheli represents an example of good practice that needs to be secured and replicated through secure funding. For women who were accessing these mental health services having been signposted to them from a refuge or outreach service, the absence of abuse is likely to have created the ideal context in which the women could begin to recover their sense of self worth and mental well-being. However, women need to have continuity of care if these gains are to be built on.

“I was very anxious and depressed because of my situation at home. I was left on my own to look after my children and my in-laws after my husband died. My in-laws and their eldest son shout at me, my brother-in-law misbehaves (euphemism for sexual abuse) with me. ...I was able to contact the student counsellor at the local centre. I felt much better that I had someone who was listening to me. I saw her 4-5 times, then she left. The medicines gave me a lot of side effects but it did help me

to relax. I would have liked to see the counsellor for longer as that was helping me.”

Women also particularly valued having a space where they could come together with other women to discuss their problems, support each other and exchange information about services:

“I went there for six months and I found it very useful. ...I am part of Roby women’s group and we have been discussing different matters. I came to know about many things which I was not aware of.”

“I contacted Neesa three months back. ...They hold groupwork and classes. It keeps you busy and you forget your problems for a while. I attend them every week now... There is always someone there to talk to me, and there’s practical help – ESOL, sewing classes, poetry.”

A few women reported greater ease of access to voluntary sector organisations which serve a diverse clientele because their visit could not be linked to domestic violence, as in the case of specialist domestic violence services. For South Asian women in this situation, drop-in sessions from a specialist domestic violence outreach service, or robust mechanisms to screen for domestic violence, signposting and referral would be effective.

“I have heard of the above groups (Saheli and Hosla), but I am not sure if I would use them. I don’t want any one to think that I am being beaten up at home. Someone has told me that at Roby they are running a group for Asian Women, it is very far away from my home so I have not tried it yet...I think I might.”

Services contacted for help with Domestic violence

The third part of this section examines women’s experiences of seeking advice, help and support in the specific context of the domestic violence they have faced. Their experiences and perceptions of a wide range of agencies including domestic violence

services, health services, police, social services, law centres and advice services, community organisations and religious/faith groups are explored. Contact with these services often takes place when the abuse escalates. Women were asked to list the services they had approached to seek advice/help about the domestic violence they had faced from a list of options, with an opportunity to record services not on the prepared list. Further questions were asked to explore the nature of this contact, when it was first made, the number of times women accessed the service and their service experiences.

Specialist domestic violence services: Saheli and Hosla¹¹

South Asian women interviewed for this study were unanimous in asserting the need for specialist domestic violence services, and for many women, the existence of this support was the crucial variable that enabled them to leave abusive relationships and rebuild their and their children's lives. Women interviewed for this project indicated that their contact with specialist domestic violence services were the most enduring, both for women who had left the abusive relationship (22 women) and for women who were still living within the community (13 women).

In working to ensure diversity, it is 'important not to make assumptions or homogenise groups but to recognise the complex and multiple needs of a changing population' (Thiara 2005: 3). For example, Thiara (2005: 3) points out that the needs of South Asian women born in the UK are likely to be different from those born and raised in the sub-continent. Equally, no community is static, and the needs of different groups are likely to shift and change. Ensuring equal access to services is not simply about adding a notional worker or diversity policy to present structures – add diversity and stir – it is about understanding the needs of Black and minority ethnic women and altering service delivery and structures. This would require an understanding of the structural constraints that shape a South Asian woman's agency in response to the abuse she is enduring such that her needs are integrally addressed at all levels of service planning and delivery.

Leaving the abusive relationship is often seen as the end of a woman's problems. However, research indicates that women have ambivalent feelings of guilt and shame accompanied by very low self esteem at this point (Dugan 2000; Hoff 1990; Kirkwood

¹¹ This specialist outreach service for South Asian women in the Manchester region has since been decommissioned, a process that is taking place across the country with specialist domestic violence services whose existence is coming under threat due to changes in funding priorities.

1993). South Asian women, in particular are often deeply traumatised as they have not only lost contact with many family members and moved house but are also shifting their whole sense of reference and self-identity which may be closely tied to their belongingness within their community. Breaking the silence and vocalising the suffering and victimisation associated with domestic violence is seen as putting the self above the family. To do that, in South Asian cultural traditions, is often perceived to be more immoral and shameful than even rage and violence (Gill 2004; Izzidien 2008). This adds to the enormous pressure to go back to the abusive relationship. For many women interviewed in this study, having culturally sensitive support in their language was crucial in enabling them to leave and sustain the change. While not all women choose specialist services, research indicates that for South Asian women who do not speak English, these services are a lifeline. Language is great importance to women who are reluctant to access or approach services and can be a huge barrier (Parmar et al. 2005). Women are often unable to access written information and interpreters are rarely present in many mainstream agencies. Previous research indicates that the availability of sensitive and sympathetic support in appropriate languages is crucial to enable women to rebuild their lives (Rai and Thiara 1997; Thiara and Hussain 2005; Thiara 2005).

“The Homeless Person’s Unit told me about Saheli. I went to them many times... it gave me new courage. I could discuss my problems... They could guide me in my language.”

“I went into a deep depression and was referred to a counsellor by my GP. At the surgery, I picked up a leaflet about Hosla project. I received support from the South Asian Outreach Worker at Hosla project. Hosla has supported me for over a year now. I met other women through their group work - it felt better talking to women who understood my problems and their worker also met me on a regular basis... I could speak to her. It was very good that they had a Bengali worker.”

Research indicates that that for a range of reasons including extreme isolation and feelings of shame and guilt, South Asian women find it harder to leave situations of domestic violence and perceive greater pressures to reconcile (Gill 2004; Rai and Thiara 1997; Shah-Kazemi 2001). Women who have experienced abuse from multiple family

members, who have no recourse to public funds, who speak no English, whose children are abducted, who are new to the country, all present with complex issues (Choudry, 1996; Menjivar and Salcido, 2002) because of which many South Asian women require high levels of support and over a longer period of time.

“When I managed to escape from my husband I had no idea of life outside and didn't know how to shop, how the currency worked, how to get to the children's school, what and when there were school holidays, what day of the week it was, how to use public transport, and how to communicate in English.” (CRP VAWI Asian project user, quoted in Parmar 2005: 7)

A recent Home Office publication recognises the extra resources that are needed in meeting these needs, *“Projects should be aware of the needs of BME women and the costs of these when the project is being developed”* (Parmar 2005: 8). However, under Supporting People, specialised refuges are increasingly being pressurised to bring their support costs down in line with mainstream services, to diversify or merge with mainstream services (Anitha 2007; Thiara and Hussain 2005). The extra costs associated with meeting the high support needs of many Black and minority ethnic women is recognised in policy briefings and Home Office research, but is seldom translated into resource allocation. For example, the refuge sector is deemed to cater to women with low to medium support needs, and refuges are pressurised to move women on as quickly as possible. Neither of these practices reflects the experiences of South Asian women or offers them the extra and sustained support necessary to move towards independent living (Thiara and Hussain 2005).

“At Saheli I got shelter. They helped me to get my benefits, ...arranged a lawyer for me. They helped me to get my indefinite stay, my own home. Hosla helped me when I moved into my house – they taught me how to survive independently. Before coming here I was so scared and isolated... I had no idea how to do things, where to go with my baby. I had suicidal thoughts... But now I am happy... I am living independently with my baby. I have no fear, no stress.”

“I have been supported by them (Hosla) for more than a year. I ... attended their group work and spoke to them regularly on the phone. Their outreach worker supported me.”

This research reinforces previous research findings, in which women have consistently found that domestic violence services run by women’s organisations, particularly refuges and outreach services, have been most effective in meeting their needs (Kelly and Humphreys 2001; Mullender and Hague 2001). Their long experience in working on this issue, their tendency to listen to the women, avoid colluding with the dominant attitudes to the abuse, their validation of women’s experiences, the combination of practical assistance as well as emotional support, as well as long term support makes them the ideal services in enabling women to restore their sense of self and sustain independent living. However, recent shifts in government policy under the discourse of community cohesion have resulted in a shift in government funding priorities, with the funding of ‘single identity’ groups coming under threat. Specialist refuges and outreach services across the country have faced closures or pressure to merge with mainstream services (Anitha 2007), thereby closing the one avenue that South Asian women have found most effective.

Other Women’s organisations: generic refuges and domestic violence helplines

Seventeen women accessed support from generic domestic violence services like refuges and domestic violence helplines. For some of the South Asian women interviewed in this study who had managed to leave the abusive relationship, a generic refuge was the first place that they went to, following a referral through the social services, or a contact with the police.

“The social services put me into a (mainstream) refuge where I had a very difficult time... Nobody could understand me and there was no one I could talk to for days. I felt so scared and confused...When I moved into Saheli, I could talk to the worker and explain what had happened to me, I could talk to other women.”

Most women reported a sense of relief at having escaped the abuse. However, the language barriers and lack of cultural sensitivity meant that many of the characteristics

of refuges that make them so effective (discussed above) are unavailable to them, and they remained little more than a roof over their head. The emotional support, as well as model of empowerment that is crucial to sustaining independent living can only be possible where women are able to engage with the services effectively and feel confident that the services are able to recognise and respond to their needs.

Other services like the Domestic Violence Helpline and other phonelines run by women's organisations were crucial first points of assistance, particularly for women who had little knowledge of what services were available, or who had little opportunity to access other services.

"I got a lot of support from Domestic Violence Helpline. They helped me to go in the right direction."

Some women reported a disappointment at the lack of support for women who were living within the community. While most women do eventually leave the abusive relationship, it can take a long time. The availability of support during this period of assessing their options, which can take weeks, months or in some cases, years, is one of the crucial factors in enabling women to leave.

"The Domestic Violence Helpline did not help me. They said, "Just leave him." At that time I did not want to do that. I am now going through my divorce."

Accident & Emergency services (A & E)

Twelve women contacted the A&E for help following injuries as a consequence of domestic violence. These women reported giving explanations which pointed to causes other than domestic violence due to a combination of factors like presence of family members there, fear of further violence and stigma. However, none of the women's injuries were probed further by the A&E staff.

"I was hospitalised (because of the violence) and had to pretend I fell down the stairs."

Obstetric services: Midwives and health visitors

Of the 72 women interviewed, 59 had children, which made obstetric services a crucial point of contact where women may not have unfettered access to other services.

“When I had my children, the health visitor used to come to my house every other week. I was desperate at that time – I told her about my problems and she told the social services. They put me in touch with Saheli. They were very understanding and caring.”

“I was sixteen when I was married to my cousin and came to this country. I am from a very poor family in Pakistan and my parents could not give me any dowry, so when I came here my in-laws began to abuse me. They always said, “You did not bring anything with you. We have incurred a loss by getting our son married to you.” After one year I gave birth to a son. I had no permission to breastfeed my baby because my mother-in-law always used to say, “This is our blood, so you can’t give him your milk.” My in-laws always threatened me that if I complained, they would take away my son and send me back home... I was always depressed, I lost a lot of weight.

During my second pregnancy, when I used to go for my monthly check-ups, I told my midwife a little bit about my situation. She was sympathetic, she gave me emergency contact numbers. I was happy with the advice and help I got from her. After I gave birth to my baby, I decided to leave home. I told my health visitor everything and she contacted the social services... I took my baby and ran away when nobody was at home. A social worker arranged a place in a refuge for me... I was relieved that I had escaped from my in-laws, and now no one can abuse me. I have a right to feed my baby and bring him up as I want to. I have no stress, depression and fear now. I can talk to my parents freely. I am so relaxed in my own home with my baby now.”

In this case, a positive response from one agency enabled the woman to have the information based on which she could later make the decision to leave. Women

enduring domestic violence are seldom able to follow advice from service providers to leave the abusive relationship immediately. On the whole, women reported greatest proactive screening for domestic violence from health visitors and midwives. Where they reported mental health problems, they often indicated that the causes had been explored by obstetric services far more consistently than by other NHS services, if no language barriers existed. Again, provision of interpretation services would prevent Black and minority ethnic women who cannot communicate in English from slipping through the net.

“I was not satisfied with my GP but was very satisfied with my midwife. She was very helpful not only for my pregnancy related problems but also used to ask if there was any domestic problem (domestic violence) at my home. ...she used to keep saying, “We can help you with that.” Though I could not take up her help, it was good to know that she was there and that she was understanding.”

Women’s actions in the face of such oppressive contexts can be understood as an interplay of structural constraint - the power inequalities and the potential for exploitation - and women’s agency understood as ‘the socio culturally mediated capacity to act (Ahearn 2001: 112).’ That this agency can be emergent at particular situations, places and times has been noted (Ahearn, 2001), but what has been less explored is how personal histories, emotions, motivations, institutional arrangements, access to information and perceived access to services, all have bearing on how agency is played out. Women’s perception of their situation, and thereby the exercise of their agency, their ‘choices’, change over time based on a shift in all these configurations.

Social services

Women interviewed for this study accessed the social services through a number of routes which included referrals or signposting from their GPs, the police, midwives and health visitors, community organisations, Domestic Violence Helpline and through direct contact with social services after they had heard about them through their informal networks – altogether twenty women mentioned contact with social services to access help and support regarding the domestic violence they were enduring. Again, depending on a number of factors like their understanding of domestic violence, the nature of the

service response and particularly the accessibility of these services surrounding language and cultural sensitivity, South Asian women had varying experiences of social services. Women were satisfied with these services where their needs were understood, they were presented with options but not pressurised to follow them, were treated with respect and received both emotional and practical support.

“They provided me with good advice and never pushed me to do anything I did not want to do. After talking to them I knew there was help out there if I needed it.”

“I was mentally very disturbed when I was leaving home because I had no money, no friends. I was so scared, I was only a teenager, so I had lots of fears about approaching these services... When I contacted social services they supported me a lot. I’ve been given loads of choices that people could help with. They were very sympathetic.”

However, the single most prevalent reason given by South Asian women for their dissatisfaction with social services was language barriers and the lack of understanding of the needs of a survivor of gendered violence.

“I found out about social services through the police. At that time I was in very desperate situation. I used the social services... I faced a lot of problems there. (They were) not very good because of the language... they rarely arranged an interpreter.”

“(The social services) arranged a temporary place for me - it was very bad. I was not happy because in that place, I was the only woman and all others were English people, men. That was a B&B and I spend the whole day without eating. I was alone in that place, I was so scared. At that time I really wanted Asian women to talk to.”

Police

On average, a woman will be assaulted by her partner or ex-partner 35 times before actually reporting it to the police (Yearnshire 1997: 45). Despite this, police remained the single service that was directly accessed for domestic violence by the greatest number of women (23) interviewed for this study. This is probably because of the high level of awareness of police, as compared to other services, access to which were through diverse pathways.

Despite changes to policies which were meant to signal a move away from earlier attitudes that regarded domestic violence as less of a crime than assaults on strangers (HOC 19/2000), research indicates that the practice of different police forces varies widely with regard to domestic violence (Avakame and Fyfe 2001; Buzawa and Buzawa 1990; Grace 1995; Hanmer and Griffiths, 2001; Kelly 1999; Plotnikoff and Woolfson 1998). Accordingly, women's experience of contacting the police varied widely, depending on police attitudes, understanding of domestic violence, response to the woman and action with regard to the perpetrator(s).

Where women's experience of domestic violence was taken seriously, a pro-arrest policy was followed and the safety of the women prioritised by informing them about their options and making contact with services on their behalf, women reported positive experiences of the police.

"I called them three years back – they warned my husband and gave me different numbers to call and told me about the places I could go to for help. It encouraged me a lot."

"Police helped me and arrested my husband. They talked to the support worker and then they arranged a place for me in Saheli."

Even if they did not wish to leave the abusive relationship at that point in time, women who had such positive experiences called the police again, and reported feeling encouraged by the support they had received.

"When I was beaten up, I called the police... (they) were helpful, gave me advice and numbers; it was useful...due to my

own fear of being disowned I did not use the services. After a while I slowly realised I had to change my attitude and not take the abuse. Women in this situation struggle to get enough confidence to speak up in first place.”

On the other hand, lack of sensitivity to the gendered nature of domestic violence, absence of systematic and consistent recording of domestic violence incidents, poor or no evidence gathering techniques at scene of crime, and above all, the language barriers faced by many South Asian women contributed to poor perceptions of police response to the problem of domestic violence.

“I called the police first but I did not want to talk to male staff. I can’t speak English very well. They did not arrange an interpreter, I told them very little, hardly anything at all...”

“I called the police but they never took my statement. I was not happy with them.”

Law Centre/ Citizen’s Advice Bureau

Nineteen women reported contacting the Law Centre and 13, the Citizen’s Advice Bureaux often for help with regularising their immigrations status, obtaining injunctions and initiating divorce proceedings. Many women who had contacted these services had done so as part of the support they had been receiving from the specialist domestic violence services in Manchester (Saheli and Hosla), were supported in this process, and reported positive experiences of CAB and the Law Centre. For a few women who had made this contact by themselves, their experience depended on their ability to speak English, or the accessibility of these services through an interpreter or the availability of advice in their language. On the whole, women who had advocates had better experiences than those who did not[0]

“Through a tutor in the university, I found out about the Law Centre and CAB. I used the services a few times, a few years ago to help me decide what I want to do in the future. They gave me advice and information on further support e.g. solicitors and re housing.”

Q: Were you satisfied with the service?

“They offered support, it was informative. ...I felt better knowing support was out there, their workers were very sympathetic.”

“One of my friends helped me to approach the law centre. At the law centre I wanted to register my case for indefinite stay. They helped me to get my indefinite stay. The lawyer told me about Saheli. ... at that time I had no shelter, I was isolated... I also wanted an Asian worker.”

Community Organisations

Ten women had contacted community organisations, and reported benefits like a supportive environment, a chance to talk to other women, gain practical skills and get emotional support and advice for the domestic violence they were facing.

“Through family and friends and women I met at my English classes, I found out about it (community organisation). I went to them... a few times over 5 years...made me feel better, released, refreshed and made me look at things in different ways.”

“I went there for six months and I found it very useful. They have groups of women who discuss different matters. I came to know about many things from talking to them, which I was not aware of before. But my mental well being has not really improved, because my situation, my circumstances are the same as before.”

Faith groups/religious organisations

Eleven women reported contacting faith groups/ religious organisations for help and support relating to the domestic violence they were facing. Some women reported positive experiences, particularly reporting that these organisations enabled them to overcome isolation and interact with others. However, none of the women reported any explicit initiative or support from these organisations that addressed the issue of domestic violence or their mental health problems.

“ I go there two to three times in a month. I like the atmosphere in the faith groups and also because I can talk to everyone there...”

Where any problems were discussed or alluded to, the solution that was emphasised in these contexts centred on changing the individual women's responses to their circumstances, rather than changing the circumstances themselves, or that their current circumstances are a part of a grand scheme, and therefore they need to be come to terms with their circumstances, a response that has previously been documented in other studies (Ware et al. 2004).

“...they talk about positive things and give examples of how our attitude and our response to situations can make us feel better. With the faith groups, I have been satisfied because I have learned through their teaching that everything happens for a reason...”

On two occasions, where women attempted to discuss the abuse they were facing, one with a helpline (now closed) catering to Muslim women, and the other with a faith group, they reported attitudes that colluded with dominant myths about domestic violence and a failure to validate the women's experiences, or offer support and advice.

“I found out about them on the yellow pages, but they hung up after three minutes. ...they put the phone down on me when I said I wanted to divorce my husband. I phoned them for religious advice and they made me feel so angry when they were so rude and judgemental...”

“We need these services but by people who are monitored and professional...”

Till recently, under the rubric of multiculturalism, the British state has been upholding religious communities as the new 'ethnicity,' as culture and religion came to be conflated (Wilson 2006: 75). In this foregrounding of faith communities as the true face of diversity in the UK, women's voices were often subsumed within the dominant

voices. Wilson (2006) has documented the role of religious groups (Hindu, Muslim and Sikh) among South Asian communities in the UK and in South Asia in upholding the public/private, the male/female dichotomy, and in strengthening the notions of honour. Given the gendered nature of domestic violence and the role of patriarchy in upholding the inequalities which foster forms of violence against women, religious organisations have a role to play in providing services to women only where they are willing to unravel the moral codes which uphold patriarchy. Given the number of women accessing religious/faith groups, they can serve as useful places where information can be disseminated about services. However, any service delivery will have to be carefully monitored so that women's options are opened up rather than closed off due to contact with these services, and the confidentiality and quality of services delivered will need to be evaluated.

Women's experiences of complementary therapies

This section explores women's experiences of using complementary therapies to improve their mental well-being. Women were asked to list their use of complementary therapies, and further questions were asked to explore the nature of this contact, when it was first made, the number of times women accessed the service and their service experiences.

Several women reported using complementary therapies to improve their mental well-being, both at community organisations, through Hosla and privately. While the therapies that women accessed are varied, and there has not been much research into the effectiveness of these therapies in the context of domestic violence, women reported positive experiences of accessing such services. Apart from homeopaths, whom some women accessed privately for help with their mental health problems, most of these therapies were accessed through community organisations and domestic violence services, or through referrals from health services, where they were available. The symptoms that women sought help with included weight loss, loss of appetite, weight gain, restlessness, anxiety, panic attacks and headaches. Many women reported noticeable gains from accessing these services, particularly short term and symptomatic relief that helped them cope with the impact of the domestic violence on their mental health. These services were particularly sought by women who did not wish to use medication for their mental health problems.

“I enjoyed the massage very much, I felt relaxed.”

“The antidepressant tablets were not working, so I tried several things – acupuncture, herbalist, massage. I did feel some improvement after using them.”

“I used acupuncture after the birth of my baby girl. I use Reiki and massage whenever I am stressed and tired. These services help me a lot... to feel relaxed in my mind and body.”

“Through friends and other agencies I was using at that time I found out about the fitness centre - about 20 years ago when I just got married. Since then I have used mainly the fitness centres. It helps me feel less stressed.”

Apart from the benefits outlined above, rather than a one-off contact providing advice and information which women may not feel ready to act on, the complementary therapies often gave women a reason for repeated and sustained engagement with services. It is in the context of such a sustained contact that information and advice as well as long-term work, including groupwork, to address the mental health problems and domestic violence can often take place.

“I found out from Hosla Project (about the Reiki on offer) and used group work Reiki for few weeks when I was ill. ... I had a taster session and found it very good. It helped me to relax, so I had it few times. I was satisfied. Reiki helped me, I then used to have it done privately.”

Addressing symptoms not causes

However, the potential of complementary therapies to offer effective holistic support to South Asian women experiencing domestic violence and mental health problems has not quite been realised in some of these therapies that women have accessed, particularly in the case of service providers who have not engaged with the causes of the mental health problems or lack an understanding of the nature of domestic violence.

“I had acupuncture... Because of my language problem, I could not talk to them properly, explain my pain to them. Although they helped me with the physical pain, and that helped me feel better mentally, I wanted to talk to them about what was in my mind, tell them about my husband, but I could not.”

“I used to go every two weeks, about 6 months back. I tried Reiki and massage and it helped me to relax. But I did not discuss my personal problems. I am too scared and depressed to tell anyone, and it’s very embarrassing to talk about it. Your family is supposed to be good to you – how can you speak against them”

The underlying causes of their symptoms are clear to women approaching these therapies, as is some women’s willingness to talk about their experiences. However, professionals providing these services need to be able to ask the right questions to identify the causes, know how to respond to the women and be able to signpost them to other services.

These therapies provide a valuable additional service for South Asian women who may not feel ready to access domestic violence or mainstream mental health services. For many women who have reported that the stigma of mental health problems and the constraints surrounding disclosure of domestic violence prevent them from accessing services, a service providing complementary therapies may be a space that is perceived by perpetrators as apolitical, providing individual solutions in non-confrontational settings, access to which may not be barred.

While these complementary therapies can be used in conjunction with other services to enhance emotional and physical well-being in the long term, many women interviewed for this study have reported use of these complementary therapies to provide short term relief for symptoms of mental health problems and the pain caused by physical violence. If the use of these therapies remains an end in itself, rather than a part of a concerted, pro-active multi-agency response to the problem of domestic violence, then an opportunity for identifying underlying causes rather than dealing with symptoms would have been missed.

Women's assessments of service outcomes: Improvement in mental health?

Given the link between domestic violence and mental health problems articulated by a majority of the South Asian women interviewed here, it comes as no surprise that many women linked the improvement in their mental health to the end of their abusive relationship.

“After contacting these services (Hosla and Saheli), my physical and mental health has improved. Now I am back to normal. I am living independently and very happily in my own flat.”

“Now that I am separated from my husband, I do feel stronger – more at peace with myself.”

Where services had made co-ordinated responses to the problem of domestic violence, women reported high levels of satisfaction and an improvement in mental health and increased ability to sustain independent living.

“I used three services. First I contacted my GP and told him about some of my problems. He advised me to contact social workers. Through the social worker I came to know about Saheli. I am satisfied with both these services. My GP helped me to improve my health. Police helped me and arrested my husband. After leaving my house, I was so relaxed (that) I gained weight. My financial state is improved. I am happy that I am now living in a free environment.”

Several women who reported no improvement in their mental wellbeing despite seeking help from mental health services (including GP), as well as women who had contacted services (police, community organisations, specialist outreach services or faith groups) for help regarding the domestic violence they were enduring cited the reason for their continued mental health problems as continued abuse.

“Despite using tablets for depression, I do not feel any relief because I am still experiencing domestic violence.”

However, leaving the abusive relationship does not by itself resolve the mental health needs arising from the impact of the abuse. Research has documented the short term as well as the long term effect of domestic violence on mental well being, and the effect can last long after the end of the abusive relationship (Humphreys and Thiara 2003; Kirkwood 1993; Mooney 1994). Women who have survived years of being put down, of having their feelings and emotions disregarded, of being humiliated and degraded, need a safe space, practical support as well as specialist help from mental health services to restore their self esteem and sense of self-worth – a process that can take months, if not years.

“I have experienced domestic violence all my life – as a child and after marriage. Now I have left my husband and am getting divorced. But nothing has got rid of my problems – I am still depressed and confused. There is only so much that these services and friends can do (had not received specialist mental health support).”

Based on South Asian women’s experiences in this study and elsewhere (Thiara 2005), it could be argued that it is within the empowering context of domestic violence services, particularly specialist services, that such support would be best provided.

Conclusion

Contrary to early research and continuing ‘common sense’ perspectives reflected in media reports on forced marriage, which portray South Asian women experiencing domestic violence as passive victims of a patriarchal culture, South Asian women interviewed for this research made several attempts to contact services, and continually assessed their options. This research has shown that despite barriers, South Asian women experiencing domestic violence and mental health problems do reach out to services. The seventy two women interviewed for this study between them made contacts with 80 services for help with mental health problems, with 153 complementary

therapies and 229 contacts which explicitly sought remedies for the domestic violence they were enduring. These figures do not include repeated, separate contacts with the same service, which many women reported making over months or years, particularly in the case of GPs. They represent an average of 6.4 different services for each of the 41 women who had previously endured domestic violence and the 31 women who are still living in abusive relationships, who will presumably make many more contacts with services before they get the help that they need.

Women experiencing domestic violence and mental health problems seek help from a variety of sources. However, South Asian women's ability to leave an abusive relationship and to engage with and benefit from mental health services depends largely on the responses of these services. While the personal history of the woman plays a part in when and if she perceives herself as able to leave an abusive relationship, her evaluation of the support available and the accessibility and suitability of the service are the key factors in this exercise of her agency. The next section explores the recommendations that go towards addressing the gaps perceived by the women interviewed for this study in the services that they contacted.

5.4 Reflections, conclusions and recommendations

These recommendations are based on the data from this research and indicate both the specific suggestions made by South Asian women interviewed for this project who were presented with a range of choices to improve accessibility to services and service delivery, as well as the recommendations that emerge from an analysis of their service experiences.

Barriers to accessing services: some reflections

Despite a high degree of service contact by many South Asian women, there remain barriers that prevent many South Asian women from accessing services effectively, or in the case of many women, prevent them for a period of time from accessing services. Interviews with women who had migrated to the UK following marriage revealed that they initially faced extra barriers which some women managed to overcome over time.

Barriers preventing access to services

In response to the question, ‘what are the barriers that prevent South Asian women from accessing mental health and domestic violence services,’ several barriers were discussed and women recounted their personal experience of these barriers when they had contacted services. 41 said women were not aware of services, 34 identified language barriers, 33 identified fear of further violence. Other barriers stated included fear of shame and stigma and fears about the lack of confidentiality, difficulties accessing services, lack of childcare facilities, family pressure, lack of confidence, inappropriate location of services and fear of discrimination, which prevented South Asian women from accessing services.

“I was not allowed to go outside. I was not even free to talk to anybody within the house. I was not allowed to attend the phone. I had lost my confidence, I was not aware of these services. I had some language problems because I could not speak English properly at that time.”

“Most women are too afraid to seek help as they are afraid of family members reacting, many women are unable to access information due to language barriers or being accompanied at the time.”

“I think most women put up with it because they see it as a norm. They are also scared that they (service providers) will tell someone, they worry about their honour and respect being stained.”

Lack of awareness

Lack of awareness of services was a particular factor for women who had recently migrated to the UK, but also for other women whose movements had been restricted because of the control exercised by the perpetrator(s) of domestic violence.

“ I was not aware of services for domestic violence, but now I know about what is there in Manchester – I will be using them.”

Fear of domestic violence

Many women reported being unable to access services because of the fear of domestic violence or due to the control exercised over their movements.

“ I was unable to attend the counselling sessions because of the situation at home...I could not go to these places because I could not tell my family where I was going, and I found the pills addictive, so I stopped them.”

“I am having so many problems at home (being forced to marry) – if my parents found out that I was talking to you about it, or that I would contact organisations about it, they would kill me. In Asian families, mental health or domestic violence are things no one wants to talk about or hear. They pretend it does not exist.”

“I don’t have the confidence, I am scared to talk to anyone because it may get back to my family. ...the situation at home prevents me from going to services...what if someone found out and told my family”

Cultural factors like stigma, ‘badnami’ (bad name) and ‘izzat’ (honour)

The pervasive influence of cultural concepts like honour have been discussed earlier, and women recounted how these notions impeded them. However, appropriate services which understand women’s concerns about confidentiality and their fears about shame and stigma due to their help-seeking can overcome these barriers.

“I suffered, but I did not contact any organisations because my family is well known, I didn’t want to destroy their reputation, their honour.”

“All the shouting, fighting, accusations had a very bad effect on my mind. It has taken a very long time for me to forget those days. I get very upset and angry at the injustice of all the things. I get very, very upset. But I was able to access some of the services. ...I think I was able to approach Hosla because I was no longer in London where the incidents happened... otherwise

it would have been difficult for me ...what if someone found out that I getting support from a domestic violence service”

“I was offered counselling and was given details of women’s organisations but I could not use that information... I was afraid of being disowned by my family.”

Language barriers

For many South Asian women, the absence of interpreters makes accessing services very difficult. In the current political climate of hostility towards immigrants, particularly recent immigrants, the cutbacks to interpretation as well as English language classes makes it likely that these barriers will become entrenched, unless there is a change in policy and practice regarding interpretation and English classes.

“With the police and social services I faced language and cultural problems. When I used Saheli, I was satisfied because I felt no difficulty in explaining my problems. I got a safe place, all my fears were gone. I was satisfied mentally. Now I and my kids are safe.”

“The bad thing (about seeing the GP) was that my English was not good, but they never arranged an interpreter for me. So every time my husband came and translated for me. I could not say much.”

Fear of discrimination

Along with language barriers and lack of cultural awareness, fear of discrimination was also mentioned by one respondent as a barrier to accessing services.

Provision of information about services: some reflections

Women were asked for their suggestions regarding the appropriate spaces where information regarding domestic violence and mental health services could be disseminated from a list of alternatives and were given the chance to add to the list.

Most of the suggestions centred on making information available in everyday spaces like GP's surgeries, dentists, community centres, schools, libraries, buses and on the internet so that women were aware of services well before they may need to use it.

"Everyone goes to GP surgeries. Mostly every mum goes school so she can get informed of the services there."

"They should put the information where people can see it. There are many services that people use lots of times during their everyday life. So they should use these places to give information about other services."

"They should have advertisements on Asian TV."

Within an ideal service, what are the three things that you would most like to see?

Most common answers to this question included cultural awareness, gender specific workers and language; while other suggestions included accessibility, crèche, religious awareness and a space to pray.

Cultural awareness and language

Research indicates that South Asian women under use mainstream services for fear of racism and cultural insensitivity and due to language barriers (LB Islington Women's Equality Unit 1995; Thiara and Hussain 2005).

"With my GP I was ok because I did not discuss the physical violence, and only (disclosed) limited mental health issues. With the counsellor and the psychiatrist I would have preferred Asian women or someone who understood my culture. This (need) was not met. ...With the counsellor it is very difficult because things are done differently in Asian culture. It is not considered normal to talk about your problems. ...I kept feeling they do not understand what I am trying to say..."

South Asian women who were registered with GPs from their own communities, expressed concerns that their GPs knew and allied themselves with the husbands and

their families, and thereby gave advice that colluded with the perpetrators. However, the alternate route of seeking a non-Asian service provider was also fraught with the danger that one's culture and community would be essentialised and stereotyped.

"I am afraid to see Asian doctors because they might tell someone or judge me, but the white doctors don't understand my culture, my language – I cannot explain what I am going through or feeling."

"White people don't understand your situation, but the Asians condemn you and judge you."

Many women were struggling to negotiate their way through their need for a culturally sensitive service, where their language would be understood, and where they would not be discriminated on the grounds of their race nor judged for challenging the patriarchal norms within their community, and at the same time where their community would not be stereotyped. Women only spaces, particularly specialist services for domestic violence received the greatest endorsement for meeting these needs from the women interviewed for this study.

"At Saheli my cultural needs were met. I felt good among my people, I could talk in my language."

Gender specific workers

Given the gendered nature of domestic violence, women often do not feel able to trust male service providers to understand their experiences without colluding with the dominant perspectives or diluting the problem, or simply feel unsafe in the presence of men.

"I could talk to women about my problems...Health visitor and social services were very good. They could not speak my language but they arranged an interpreter for me, so I could explain my problems to them."

“I spent the whole day with male staff, I wanted to do my prayers. But they had no arrangements. They had no Bengali worker. No one who could understand my problems, my culture.”

Childcare

For women with young children, lack of childcare facilities made it impossible to access services which did not provide a crèche. All the women interviewed for this research who had children, as well as many who did not, had primary and often sole responsibility for the day to day care of their or their family members' children.

“I was forced to marry by my family. After I got married, I could not study any more. Once I had children, it became very difficult to go to services because there was no one who could look after them while I was away. So I could not take up the counselling that I was offered.”

“I used each service just a few times, usually after the birth of my children - health visitor, midwives and health centre - they would tell me about other services... they gave good advice, but I never had time to use it... I had children and no one would look after them ... more help was offered but I couldn't take it. I was offered counselling but I didn't attend because of the children.”

“I tried Reiki and massage, which was good and helped me, but I could not keep it up due to childcare problems. I felt that there were people who could have helped me but I could not use their help at that time because I had to stay at home to look after the children.”

Outreach services

Many women do not want to leave the abusive relationship and their community, but need support to deal with the abuse. Women who do eventually leave also do so as a last resort, and need support to enable them to take that step (Thiara and Hussain 2005: 7). Outreach services are also crucial for raising awareness about services and providing

information to women about services (Humphreys and Thiara 2002). They can also enable under resourced yet crucial long-term work on domestic violence, with young people in local schools, and with local communities. However, these services have no regular source of funding, and Supporting People does not include any provision for such services (Thiara and Hussain, 2005: 7-8).

“I was informed by the Domestic violence helpline that I could leave home but that was not an option that I wanted at that time. I wanted support whilst living at home, which I found very little of. I would like to see more support for women who are still at home and experiencing domestic violence.”

“Contacting Saheli did not help me. There were too many options and I was confused. I did not know what I needed to do. I could not leave home at that time...”

“Something specially focused for young Asian women which is easy to access, like a drop in at schools and university. When I was in America I really benefited from ‘Teen Parenting’, which something like counselling but more tailored to young people. It would be good to learn at school that if you have problems like I have been experiencing at home then you can find help and also to know what shape that help would take. Children should be taught at age of 11-12, who to contact if you are having problems and some people can help... running away from home or self-harming are often used by children when they don’t know what to do... If (they) knew where to get help, a lot stress could be avoided.”

A few women welcomed more drop-in clinics, and facilitated women’s groups by specialist domestic violence services at community organisations.

“I would like to see special groups for women like me at Community Centres for Asian Women, more of activity clubs like badminton, meditation and yoga classes where I am able to meet

other Asian Women and make friends and do activities that take my mind away from the day to day problems.”

“It would be good for projects like Hosla to have a drop-in at local (community) groups. I think there should be more groups like self-help groups and drop-in surgeries, more resource centres for Asian Women.”

Conclusion: The way forward

Given the overlap between domestic violence and mental health problems, services in both these sectors often serve the same women; women presenting to one sector are often likely to need support in the other. Women accessing complementary therapies to seek relief for the symptoms of their mental health problems are also likely to need support from services in both these sectors. And yet, while services in each sector are able to respond to the presenting problem, they do not always provide the range of support needed by survivors of domestic violence who also experience mental health problems.

There has been research on the different models that dominate the mental health and domestic violence sectors, which often means that their understanding of the problem varies, as does their approach to finding solutions. The mental health services focus on the medical model and individual solutions to what are often seen as individual problems (Kurz and Stark 1988). “The more women are seen as clients in need of therapy rather than people in need of alternatives and choices, the less the movement challenges prevailing conceptions of the problem.” (Dobash and Dobash 1992: 234-5) While complementary therapies may aim to understand the woman in a holistic manner, their solutions, too, are geared towards the individual, personal and internal rather than the structural, political and external. Women’s organisations working within a feminist perspective understand the problem as a political one that needs structural changes in society, while focusing on safety and support for the individual women.

Failure to tackle co-existing issues in an effective manner often means that hard-pressed resources may be underutilised by repeating services without any added benefit. For women accessing mental health services because of the impact of the abuse they are

enduring, lack of engagement with the underlying causes often leads to poor outcomes, and temporary management of the problems, which are likely to recur without a change in their material circumstances. For women who are accessing domestic violence services, support around their mental health needs is crucial to overcome the emotional and mental impact of abuse. While complementary therapies play a crucial role in providing symptomatic relief and ‘holding’ women into services, their long term effectiveness depends on their ability to understand and develop effective responses to domestic violence and mental health problems. This could be through a combination of working with domestic violence and mental health services, pro-active screening, referral and signposting.

For women who are experiencing or are survivors of domestic violence, support around their mental health needs is crucial to overcome the emotional and mental impact of abuse. For women who are still living within the abusive relationship, such support may validate women’s perceptions about their relationship, which are denied or minimised by the perpetrator(s) as well as by some service providers who may collude with dominant myths about domestic violence. As we have seen in this study, such support is highly valued by women still enduring domestic violence and has a crucial role to play in their exercise of agency. For women accessing refuges, particularly South Asian women, adequate support for their mental health needs would enable women to resist pressures to reconcile, maintain their tenancy, and sustain independent living. Given the limited access of mainstream mental health services by South Asian women for a variety of reasons like language barriers and lack of cultural awareness, specialist domestic violence services seem to be ideal settings where such services can address in a holistic manner, and urgently need to be secured.

Recommendations

The following recommendations are based on an analysis of South Asian women’s service experiences and perceptions about the support they received. These recommendations relate to mental health services, services providing complementary therapies and domestic violence services. They have been laid out in this manner in order to enable organisations working in these three sectors to be able to refer to the needs of their particular sector, and some themes inevitably overlap across sectors. Some of the cross-cutting recommendations which are relevant for all three service sectors are also presented. Close attention to detail in the presentation of recommendations, as well as

explaining the recommendations with reference to the research findings makes this section long; however, it is hoped that by doing this, the case for these changes will be made more effectively.

Key recommendations for mental health services to address the impact of domestic violence on South Asian women's mental health

- **Recognise the impact of domestic violence as a core mental health issue**

Narratives of South Asian women interviewed in this research indicate that domestic violence is a crucial contributing factor in the development of mental health problems.

- **Named lead on domestic violence**

Given this connection between women's experience of domestic violence and the development of mental health problems, a key worker or specific lead needs to be identified within each NHS trust to ensure that the impact of domestic violence is addressed as a core mental health issue.

- **Policies and protocols**

There is a need to develop policies and protocols to address the gap in service responses. Individual mental health agencies need to develop internal policies on domestic violence which provide clear guidance on pro-active screening and a plan of action for clients with dual needs. These should include clear systems for referral and mechanisms for joint work with clients, and development of protocols to share information between the two sectors.

- **Service provision as empowerment**

When delivering training to the mental health sector, trainers working in the domestic violence services are also ideally placed to dispel potential myths and stereotypes about women experiencing domestic violence: constructs about women's 'passivity', persistent questions about 'why doesn't she leave'. As a counterpoint to the medical model that often dominates the NHS mental health services, these services would benefit from engaging with the empowerment model that most domestic violence services operate from and the understanding of domestic violence as a gendered exercise of power and control that underpins this model. This research shows that voluntary sector mental

health services which work closely with specialist domestic violence services have been effective precisely because of their holistic engagement with the intersections between mental health problems and domestic violence.

- **The case for specialist services: overcoming language barriers, providing holistic support**

In this study, women reported greatest satisfaction where this support was provided in the context of support and advice relating to the domestic violence they were facing. Given this, specialist domestic violence services and voluntary sector mental health services seem to be the most effective avenue to meet South Asian women's mental health needs. This research also indicates that language is a huge barrier for South Asian women in accessing talking therapies. South Asian women who might have a basic grasp of English to access GPs, found it very difficult to talk about their experiences and feelings and to respond to questions in the context of talking therapies. Such women particularly benefited from services which were delivered by providers who could speak in their language. There is an urgent need to secure specialist services.

- **Gender specific workers**

Given the gendered nature of control and exercise of power that characterises most domestic violence, gender specific services are crucial in enabling women to articulate their experiences of domestic violence and engage with mental health services confidently and effectively.

- **Pro-active screening for domestic violence**

Domestic violence is not routinely asked about by mental health services including primary care services. This research has shown that women who articulate mental health problems to professionals like GPs are often hesitant to name violence as contributory factor: many women in this study presented with symptoms like headaches, loss of appetite, sleeplessness without naming what they perceived as the cause (domestic violence). This could be because of a variety of reasons like stigma, fear, lack of trust in confidentiality, and lack of awareness about the existence of service responses to domestic violence. Violence and abuse need to be routinely asked about/detected by mental health practitioners, and where suspected, advice needs to be routinely given. This research shows that women appreciated being given this advice, even if they did not disclose the violence and were unable to act upon the advice at that point in time.

- **Role of GPs in pro-active screening**

Given the number of women interviewed who rated their GP as their first port of call for mental health problems, they can play a crucial role in pro-active screening for domestic violence. GPs should not prescribe medication, including anti-depressants without this pro-active screening.

This research has also indicated that women often do not name their experiences as ‘domestic violence;’ consequently, any such pro-active screening must be aware of this, so that the entire range of women’s experience is captured. For example, asking ‘Do you feel afraid of your partner or your (family member)’ may be a better starting point in investigating a potentially abusive relationship than, ‘Have you experienced ‘domestic violence.’

Where women attend GPs’ surgeries with their family members who are possibly there to interpret for them, GPs need to be aware of the implications this has in curtailing any meaningful response to queries regarding domestic violence or mental health, and the possible adverse impact this might have on the woman’s future service access. Access to interpretation services will enable effective implementation of this pro-active screening.

‘Environment orchestration’ in the form of leaflets about the links between mental health and domestic violence, and information about domestic violence services in various languages in women’s toilets will convey the message to women that the surgery takes domestic violence seriously, and may restore confidence and improve disclosure rates.

- **Staff training**

To implement these policies and protocols, staff need to be trained about the nature of domestic violence and the service responses to it. This training can ideally be provided by specialist organisations working in the domestic violence sector. There is a need for comprehensive training around the overlaps between domestic violence and mental health problems.

Key recommendations for domestic violence services to address the impact of domestic violence on South Asian women's mental health

- **Identifying mental health as a key impact of domestic violence**

Narratives of women interviewed in this research indicate that women experienced mental health problems as a direct consequence of the domestic violence they had endured. There is a need to recognise both short term and long term impact of domestic violence on mental health, which is not necessarily addressed by 'exit' from the abusive relationship, and often requires specialised service responses.

- **Specialist services**

Given their dual needs surrounding domestic violence and mental health problems, as well as language and other barriers faced by many South Asian women in accessing mainstream services, mental health support based in specialist domestic violence services seem the ideal, effective and safe option for many South Asian women. While mainstream organisations need to develop integrated responses to enable them to work with women experiencing domestic violence who also have mental health problems, it is also very important to develop and sustain specialist services. Evidence from this study and previous research shows that simply expecting women to find safe and effective support in mainstream services often means prolonged exposure to domestic violence and mental health problems for women and their children, repeated cycles of ineffective service delivery, and replication of services without added benefit.

- **Outreach services**

Outreach services are critical for raising awareness among women who are experiencing domestic violence but still living within the community. Outreach, advocacy and telephone support services will enable South Asian women to find out about the services available and assess their options. Specialist outreach services could organise drop-ins at community organisations, schools and other places like GPs surgeries where women can access these services.

- **Alliances across sectors**

This research indicates that close working relationships between voluntary sector mental health services and specialist domestic violence services have been particularly effective

in meeting South Asian women's needs. These relationships need to be fostered through adequate and sustained funding, and the model replicated.

- **Named lead on mental health**

Given this connection between women's experience of domestic violence and the development of mental health problems, a key worker or specific lead needs to be identified within domestic violence services to ensure that mental health problems as an impact of domestic violence is addressed as a core issue and appropriate responses are developed.

- **Policies and protocols**

There is a need to develop policies and protocols to address the gap in service responses. Individual domestic violence services need to develop internal policies on mental health which provide clear guidance on pro-active screening and a plan of action, including risk assessments, for clients with dual needs. These should include clear systems for referral and mechanisms for joint work with clients, and development of protocols to share information between the two sectors.

- **Training**

To implement these policies and protocols (above), staff need to be trained about the service responses to mental health problems. There needs to be comprehensive training to address the stigma of mental health issues and to enable staff to understand the overlaps between domestic violence and mental health. This training can ideally be provided by voluntary organisations working in the mental health sector.

- **Pro-active screening**

Mental health and emotional well being need to be routinely asked about and any problems detected by domestic violence practitioners, and where such problems are suspected, advice needs to be routinely given. This research shows that women appreciated being given this advice, even if they did not disclose their mental health problems and were unable to act upon the advice at that point in time. Following the screening, there needs to be appropriate response to any disclosure of mental health problems by referrals to specialist services, risk assessments and periodic reviews.

- **Testing services out**

A ‘taster’ session of counselling for an initial assessment, or routine referrals to in-house group work may benefit some women, or may dispel some of their inhibitions about mental health services and give them a safe way to ‘test’ the services out without any obligations. This research indicates that where women are unsure about the nature of service responses, they test them out, and where the service meets their needs, they feel confident to access them again in the future.

- **Preventative work and early intervention**

Most domestic violence services operate at points of crisis: a greater focus on preventative work and early intervention mental health work with young people who have experienced or witnessed abuse would help to minimise the long term impact of such experiences.

Key recommendations for complementary therapies services to address the impact of domestic violence on South Asian women’s mental health

- **Pro-active screening**

Complementary therapy providers need to make routine enquiries about abuse where women present with mental health problems.

- **Protocols and systems for signposting**

Systems need to be developed for signposting women and making referrals to these services.

- **Drop-ins**

Domestic violence and mental health services could provide regular drop-in surgeries at services providing complementary therapies to raise awareness and improve service accessibility.

- **Training**

Staff delivering complementary therapies to South Asian women need to receive training about issues in mental health and domestic violence, and the overlap between the two, and service responses to the problems.

- **Information and awareness**

At the very least, information about domestic violence and mental health services needs to be made available in accessible formats at the location where these therapies are provided.

- **Location of complementary therapies**

Where new initiatives are being developed to provide complementary therapies for Black and minority ethnic women, commissioners need to consider the location of these services. A community organisation where there is regular drop-in service by a specialist domestic violence service, or specialised domestic violence services seem to be ideal sites for delivering such interventions.

General recommendations for all sectors

- **Multi-agency working and joint working**

PCTs, domestic violence services, police, social services and community organisations need to forge links at frontline, practitioner levels as well as at the level of service planning. Participation in these forums should be the responsibility of named leads, and not left to interested individuals, who may move on, leading to inconsistent and patchy provision. Examples of joint working include one-stop shops, joint funding proposals, collaborative projects and joint research.

- **Training, education and preventative work**

Delivery of training can be ideally carried out through such collaborative models of working. These can also be cost effective; different sectors can provide reciprocal training to other sectors in their area of expertise.

- **Information and awareness raising**

Education and long-term preventative work need to become a priority in sectors driven by crisis intervention work. Only with such an approach will any progress be made towards the long-term goals of structural change. Work with young people and in schools is crucial to change the dominant perspectives and dispel myths about domestic violence and mental health, as is awareness-raising among the public.

This can be done by further research and leaflets in community languages. Subject to availability of extra funds, Saheli could take a lead by producing leaflets in community languages with information about the links between domestic violence and mental health and the services available, and make these leaflets available to other agencies. This will address the crucial need to inform women how and where they can get help and advice to deal with the effects of domestic violence on mental health.

- **Funding**

As always, availability of funds would enable these gaps to be plugged. The available funds also need to be utilised efficiently by directing them to services that have received most positive evaluations from South Asian women – namely specialist domestic violence services and voluntary sector mental health services in order to address dual needs holistically and effectively, thus avoiding repeated delivery of services without any added benefits or the underutilisation of services.

- **User Engagement and survivor-led services**

This research is a part of an initiative that needs to be encouraged: the centrality of service users in defining their experiences and in shaping the future of services.

- **Peer support**

In this research, South Asian women have reported reliance on informal networks of support, service awareness that is generated through ‘word of mouth’, the support that provided by getting together with other women and talking about their experiences and thereby validating them. Given this, structured and well managed peer support could prove to be cost effective yet crucial means of raising awareness, disseminating information and providing support to South Asian women experiencing domestic violence and mental health problems.

- **Issues for South Asian women**

The barriers that prevent many South Asian women from accessing services are acute and include lack of cultural sensitivity, essentialist attitudes towards their communities, and language barriers. Specialist domestic violence services and services which can provide counselling in languages other than English are crucial.

- **Services for children**

Children's needs need to be addressed by all services. These include the provision of adequate childcare and pro-active measures to access the needs of children where women make contact with services, as women indicated in this research that witnessing the abuse had an impact on children's mental health. There is also a need for long-term work to address the impact of direct physical and sexual abuse on children, particularly in the context of forced marriage, which was reported by some young women in this study.

- **Further research**

There remain many gaps in research on domestic violence and mental health of South Asian women. Issues surrounding the domestic violence faced by young girls have not been fully explored in this research, and preliminary research evidence from the 18-23 year olds interviewed for this study indicates that there remains an urgent need for further research on this subject. There has also been no research mapping the experiences of recent migrants who experience domestic violence and mental health problems, and very little information exists on the extent of this problem.

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